

EVALUATING COMMUNITY EFFORTS TO PREVENT CARDIOVASCULAR DISEASES



COMMUNITY CHANGES

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Evaluating Community Efforts to Prevent Cardiovascular Diseases

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Preface

This handbook provides guidance in evaluating community-based partnerships whose goals include prevention and control of cardiovascular diseases (CVD). Such coalitions and projects work with the community to reduce the prevalence of risk factors for CVD.

Priority areas often include:

- Improving nutrition and diet.
- Increasing physical activity.
- Preventing or reducing tobacco use.

Community-based efforts to promote health and prevent disease go by a variety of names, including coalitions, initiatives, and partnerships. We use these several related terms interchangeably. Each conveys the idea of collaboration: building a new pattern of relationships among multiple participants for a shared purpose, such as reducing risks for CVD. Coalitions enhance the opportunities for citizens to develop healthy diets and exercise habits and to stop or avoid tobacco use.

Community partnerships involve many parts of the community, such as schools, worksites, and religious organizations, to make changes that will reduce risks for CVD both at the individual and population levels. For example, a community coalition for heart health might encourage schools to modify lunch menus, religious organizations to establish walking programs, and worksites to establish smoke-free environments. Coalitions reduce risk by changing programs, policies, and practices in all relevant sectors of the community.

The strength of community partnerships—facilitating a variety of changes in multiple sectors—is also what makes them difficult to evaluate. Traditionally, evaluation methods were geared to understanding whether a particular program had an effect on a particular outcome. It is more difficult to establish cause and effect with community partnerships where a variety of citizens work to produce changes in many parts of the community at the same time.

If evaluation of community partnerships is so difficult, why bother?

**Consider whether any of the following are
compelling reasons to evaluate**

- Help partnerships review their progress and continually improve their efforts.
- Gain community support, grant money, and donations.
- Help overcome resistance to the initiative.
- Determine whether the partnership has attained its goals.
- Detect successful projects early in the life of the coalition.
- Identify unforeseen challenges and side effects and redirect efforts of the coalition.
- Acknowledge and celebrate small wins on the road to successful outcomes.
- Be more responsive and accountable to community members, grantmakers, and other constituents.

This handbook offers some practical tools that can be used to meet these and other purposes of evaluation. Using some or all of these tools can help us understand and improve community partnerships for promoting nutrition, physical activity, tobacco control, and other heart health issues.

The purpose of this evaluation handbook is to provide tools and strategies for measuring the products, effects, and outcomes resulting from the efforts of a community initiative to prevent CVD. Other coalition assessment guides have often focused more on the process of coalition building, such as the number or type of members or meetings held. Because an emphasis in this handbook is on monitoring community action and change, this system helps connect the actions of partners to the effects upon a community. When combined with other measures of process and outcome, such as member satisfaction and behavioral surveys and community-level indicators of change, this system provides a comprehensive evaluation of CVD prevention efforts.

This evaluation system is flexible: it may be used in its entirety or in its various parts. It may be used by people internal or external to the initiative. The handbook offers a number of tools that staff and evaluators of community partnerships can use to help understand and improve efforts to reduce risks for CVD.

The specific components and tools chosen to evaluate a given community partnership will be unique to each situation and to the level of resources available for evaluation. A distinction between groups with “High” and “Low” resources and requirements for the evaluation may be helpful.

The HIGH groups are those with *abundant resources* and *extensive evaluation requirements*. Users from the HIGH groups would need an adequate budget for staffing and paying for expenses related to the evaluation. HIGH users would need staff to collect and provide information plus skilled evaluators; funders or grantmakers would likely expect that a variety of questions would be addressed by a comprehensive evaluation. HIGH users should consider addressing all of the components in the evaluation system and answering all of the evaluation questions outlined in Chapters 4–9.

The LOW groups have *fewer resources* and *few or no evaluation requirements*. Users from the LOW groups may have limited staff time for supporting coalition activities and virtually no resources for evaluation. If there is any grant support, there may be little or no expectations for reporting and evaluation. Staff might be available for evaluation activities only a few hours per week or less and have no or minimal training in evaluation. LOW users should consider prioritizing evaluation questions and components, addressing a subset of questions of interest.

At various points in this handbook, we provide suggestions to guide groups with LOW and HIGH resources and evaluation requirements in tailoring the system to meet their needs. Additionally, each chapter of the evaluation system (Chapters 4–9) has a section of recommended strategies for those operating on a shoestring budget for evaluation. By applying the suggestions for tailoring the evaluation system, community-level practitioners will be able to complete useful and valid evaluations of their programs even though resources may be limited.

This handbook is divided into three parts. Part I introduces the user to CVD and community-based prevention and evaluation, key evaluation questions for CVD prevention initiatives, and the framework for monitoring and improving CVD programs. Part II presents each component of the evaluation system, its application, and sample tools. Part III addresses how to integrate the information to address key questions and communicate information about a CVD prevention initiative.

The evaluation system outlined here is based on experiences of the Work Group on Health Promotion and Community Development at the University of Kansas.¹ These experiences involve collaborations with nearly 20 different community partnerships, including those for preventing substance abuse, adolescent pregnancy, and risks for CVD. This monitoring system² has also been used with health and human service coalitions, rural health promotion, and

a tribal coalition to reduce substance abuse among Native Americans. This guide for evaluating coalitions for prevention of CVD is a specific adaptation of a more generic handbook for evaluating community health initiatives.³ Many of the examples in this CVD handbook are drawn from the evaluation of Kansas Low-Fat Eating for America Now (LEAN), a statewide coalition to reduce risks for CVD through changes in diet and physical activity.⁴

This handbook provides guidelines and tools by which community leadership, evaluators, and grantmakers can pose and address questions of interest. This is not a self-contained text on evaluation. More technical sections presume a level of expertise that could be found in many State and local health departments and colleges and universities. Our hope is that these tools can promote accountability and improvement, thus extending the capacity of community partnerships to improve health.⁵

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PART I

Introduction

What's Ahead . . .

- ❖ Overview of Cardiovascular Diseases and Community-Based Prevention Efforts
- ❖ Evaluating Community Partnerships to Prevent Cardiovascular Diseases: Some Key Questions
- ❖ A Framework for Monitoring and Improving Cardiovascular Disease Prevention Initiatives

Overview of Cardiovascular Diseases and Community-Based Prevention Efforts

CVD: What Is It?

CVD is the leading cause of death and disability in the United States. CVD, including coronary heart disease and stroke, accounts for over 43% of all deaths in the United States, and it is the major cause of hospitalization and disability. CVD refers to a wide variety of heart and blood vessel diseases, including coronary heart disease, hypertension, stroke, and rheumatic heart disease. More than 916,000 Americans died from CVD in 1990.

The two major forms of CVD are coronary heart disease and stroke. Coronary heart disease, also called ischemic heart disease or coronary artery disease, is a term used to identify several disorders that reduce the blood supply to the heart muscle. The most common types of CVD are angina pectoris (chest pain), myocardial infarction (heart attack), and sudden death. Stroke or cerebrovascular disease is the third leading cause of death and represents about one-sixth of all CVD. Stroke includes a group of diseases that affect the arteries of the central nervous system. Stroke results when an artery in the brain is either ruptured or clogged by a blood clot (thrombosis), a wandering clot (embolus), or atherosclerotic plaque.

CVD: What Causes It?

Atherosclerosis is the underlying disease process of the major forms of CVD. It is a slowly progressive condition in which the inner layers of the artery wall become thick and irregular because of plaque—deposits of fat cholesterol and other substances. CVD is usually revealed clinically in middle age or later, but atherosclerosis begins in childhood. Atherosclerosis is associated with several modifiable risk factors. These include high blood pressure, high blood

cholesterol, cigarette smoking, physical inactivity, obesity, and diabetes. Control of these risk factors at both the population and individual levels is the key to prevention of CVD. Although most of the major risk factors for CVD are modifiable or entirely preventable, over 80% of Americans report at least one major risk factor.

CVD: How Do You Prevent It?

Two major primary prevention strategies have been used in public health to reduce CVD. The high-risk approach aims to identify high-risk individuals through population screening and to refer them for treatment. The community-based approach aims to reduce CVD by changing behaviors, policies, and the environments of whole populations. Although the high-risk approach has its advantages, the pervasive and multifactorial nature of CVD makes community-based interventions that use multiple strategies a first choice. These approaches are comprehensive: they target multiple sectors of a community, such as schools and health organizations; use multiple strategies, such as information and policy change; and address several CVD risk factors, such as diet and physical inactivity.

One of the oldest community-based CVD programs is the North Karelia (Finland) Project, which began in 1972 and provided a broad range of risk factor interventions, such as messages in the media and programs for improving diet, physical activity, and reducing tobacco use. The project targeted individuals and groups as well as policies and environmental conditions that discouraged healthy lifestyles. Recent evidence suggests that this program has had significant effects, resulting in a 60% decline in the number of CVD deaths.

Early, or first generation, research and demonstration programs in the United States were supported by the National Heart, Lung, and Blood Institute. These included the Stanford Three City and Five City Projects, the Minnesota Heart Health Program, and the Pawtucket Heart Health Program. Each of these efforts was able to demonstrate successful interventions for reducing risk for some of the population or targeted risk factors.

Second generation programs, such as the New York Healthy-Heart program and the South Carolina CVD Prevention Project, funded by CDC, demonstrated that State health agencies could work successfully with local communities to plan and conduct community-wide CVD prevention efforts. Another example, the Missouri Bootheel Heart Health project, was a State Health Agency-CDC collaboration for prevention of CVD in a poor, rural six county area in the southeast corner of the state. Successes of the Bootheel coalition included

forming walking clubs, building walking trails, beginning exercise classes in community churches, providing blood pressure and cholesterol screening, and mobilizing the community around preventing heart disease.

These community-based partnerships for preventing CVD involve community members in planning and implementing local efforts. Perhaps the best known variation of this community development approach is the Planned Approach to Community Health (PATCH). PATCH was developed in the mid-1980s by the CDC in partnership with State and local health departments and community groups. It is a participatory model of community development that includes active involvement of coalition members in planning comprehensive strategies for health promotion. PATCH programs are now in 43 states, the District of Columbia, and the Virgin Islands.

Forming Community Partnerships

A variety of community partnerships have formed to reduce risks for CVD. These partnerships serve as catalysts for change: bringing about new or modified programs, policies, and practices that reduce risks. Using methods of community planning, these initiatives promote a variety of changes across multiple sectors of the community such as schools, worksites, and businesses (see Figure 1.1). *Healthy People 2000* is an excellent resource for new cardiovascular health initiatives. The health promotion and disease prevention objectives that relate to CVD provide guidance in establishing appropriate public health goals.¹

Why Another Evaluation Manual?

Experiences from several generations of community programs and partnerships emphasize challenges in monitoring and evaluating program effects and levels of effort. Program effects are difficult to document and to disentangle from effects of other efforts, influences, and trends. Data from experiments with well-controlled interventions for targeted risk factors are easier to interpret. We can examine the effects of particular interventions on particular behaviors; for example, smoking cessation programs to get people to quit, physical activity programs to motivate people to exercise, and menu marking programs to affect restaurant patrons' choice of meals.

Figure 1.1
Multiple sectors in which community change is sought to prevent CVD



Documenting such effects in community-based coalitions and partnerships is more difficult, however, since the goals are much broader and more diffuse. (In fact, in some cases we have recommended that community-based programs limit themselves to process evaluation, leaving evaluation of outcome and impact to research programs. In many cases, however, both process and outcome evaluations are required by program sponsors.) Process measures, such as the number of individuals served by a program, or changes in individual participant behaviors, such as reported diet, may be relatively easy to collect. By contrast, changes in policy or systems, changes in the environment facilitated by community partnerships, such as the addition of a walking trail or improved dietary choices in cafeterias, are often harder to document.

Community partnerships involve citizens in setting priorities and creating new relationships that facilitate community change. However, the lack of a monitoring system limits opportunities to enhance effectiveness of local change efforts. A system for monitoring early successes can provide community members, program leaders, evaluators, and funders with the opportunity to celebrate early success and redirect the partnership's energy to more effective interventions.

The Handbook: An Evaluation System

The evaluation system described in this handbook outlines a comprehensive evaluation system to (a) monitor implementation of change efforts (such as community actions to mobilize the community), (b) assess intermediate outcomes (such as changes in programs, policies, and practices facilitated by the initiative), and (c) collect behavioral and community-level measures of reduced risks for CVD (such as reported levels of physical activity).

Figures 1.2–1.4 illustrate the types of community changes that a partnership for prevention of CVD might seek in different sectors of the community.² Note that a variety of small changes in programs, policies, and practices could help reduce risks associated with diet, tobacco use, and physical inactivity.

Figure 1.2
Illustrative community changes in schools to improve diet

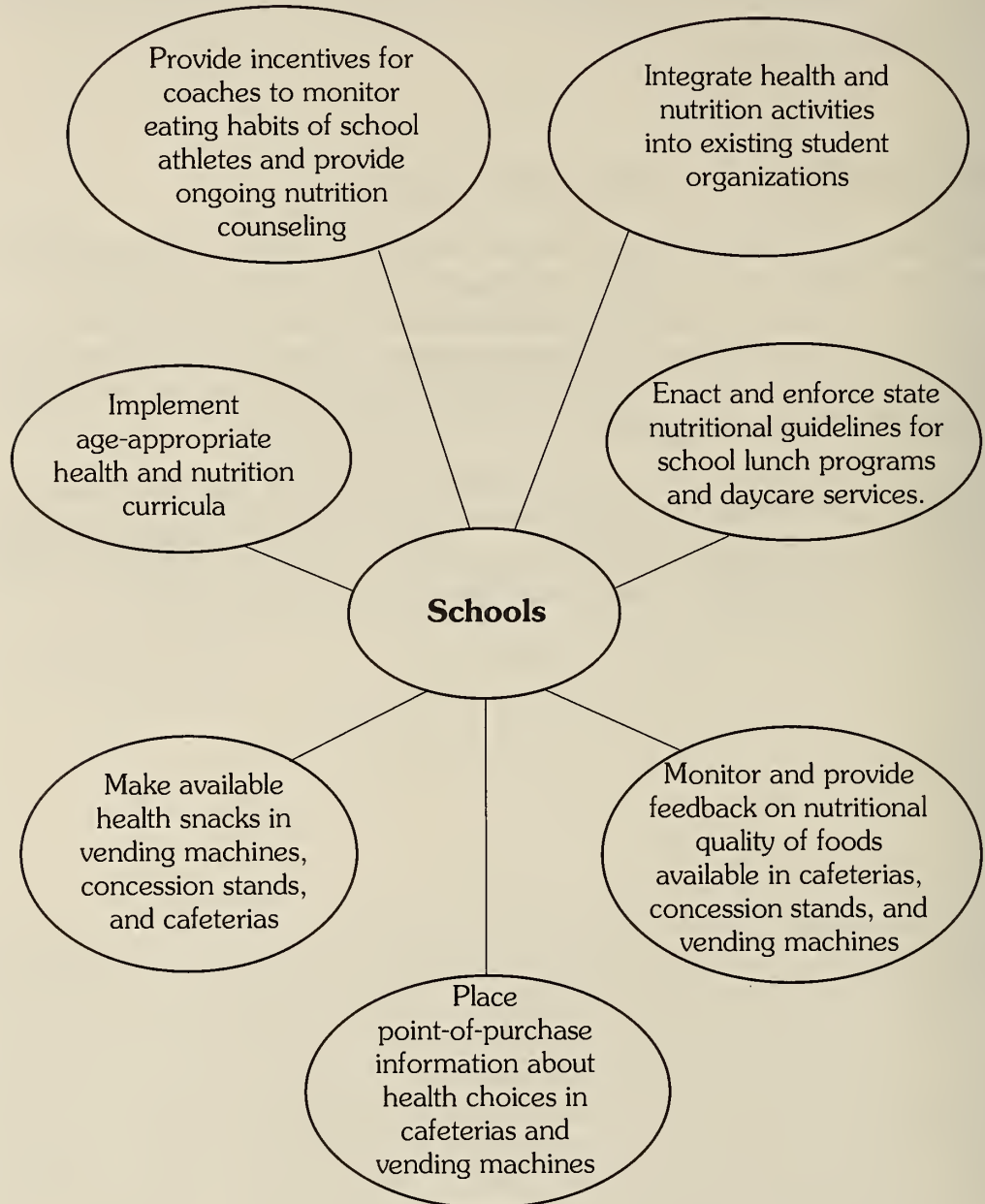


Figure 1.3
Illustrative community changes in the business community
to reduce tobacco use

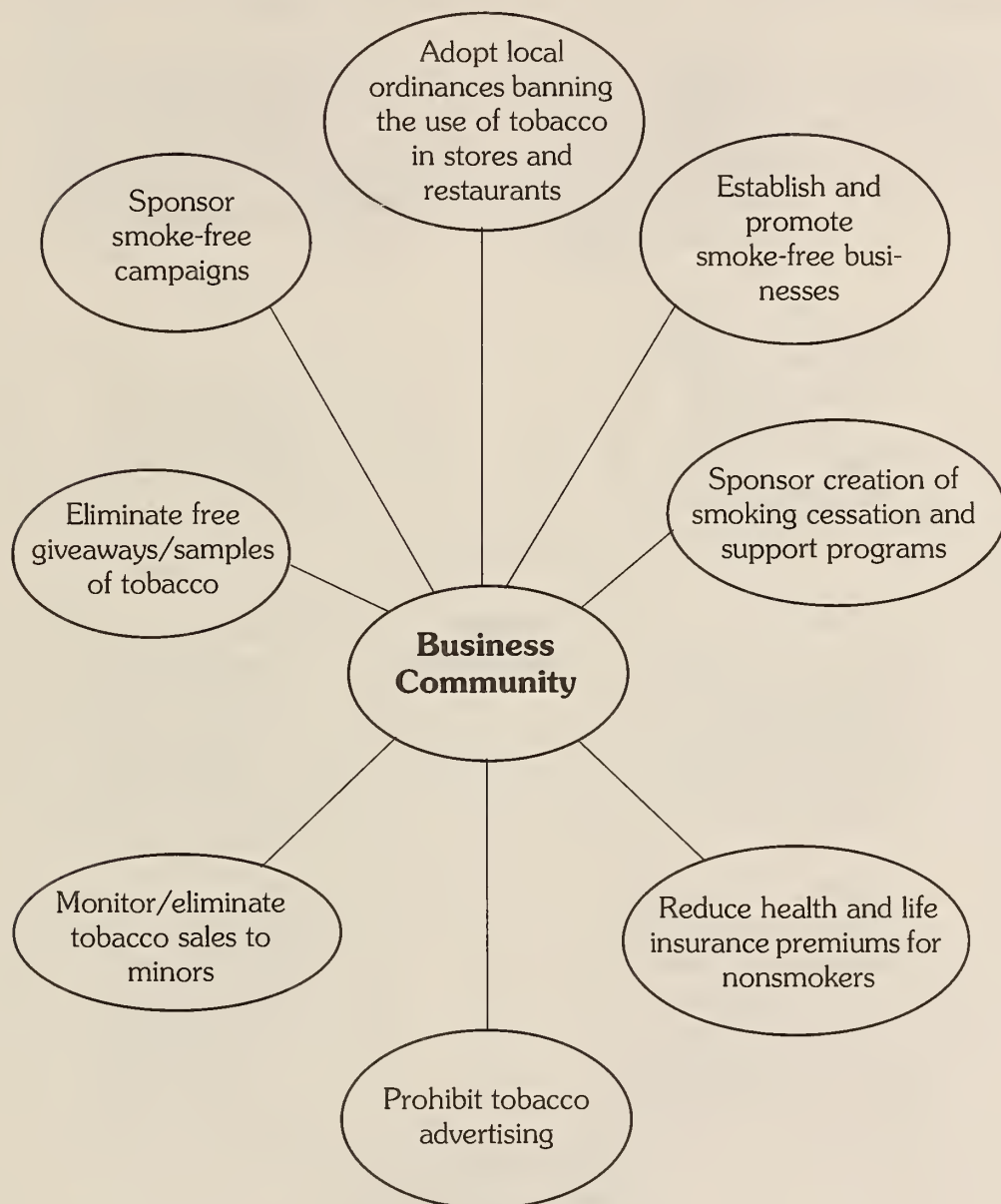
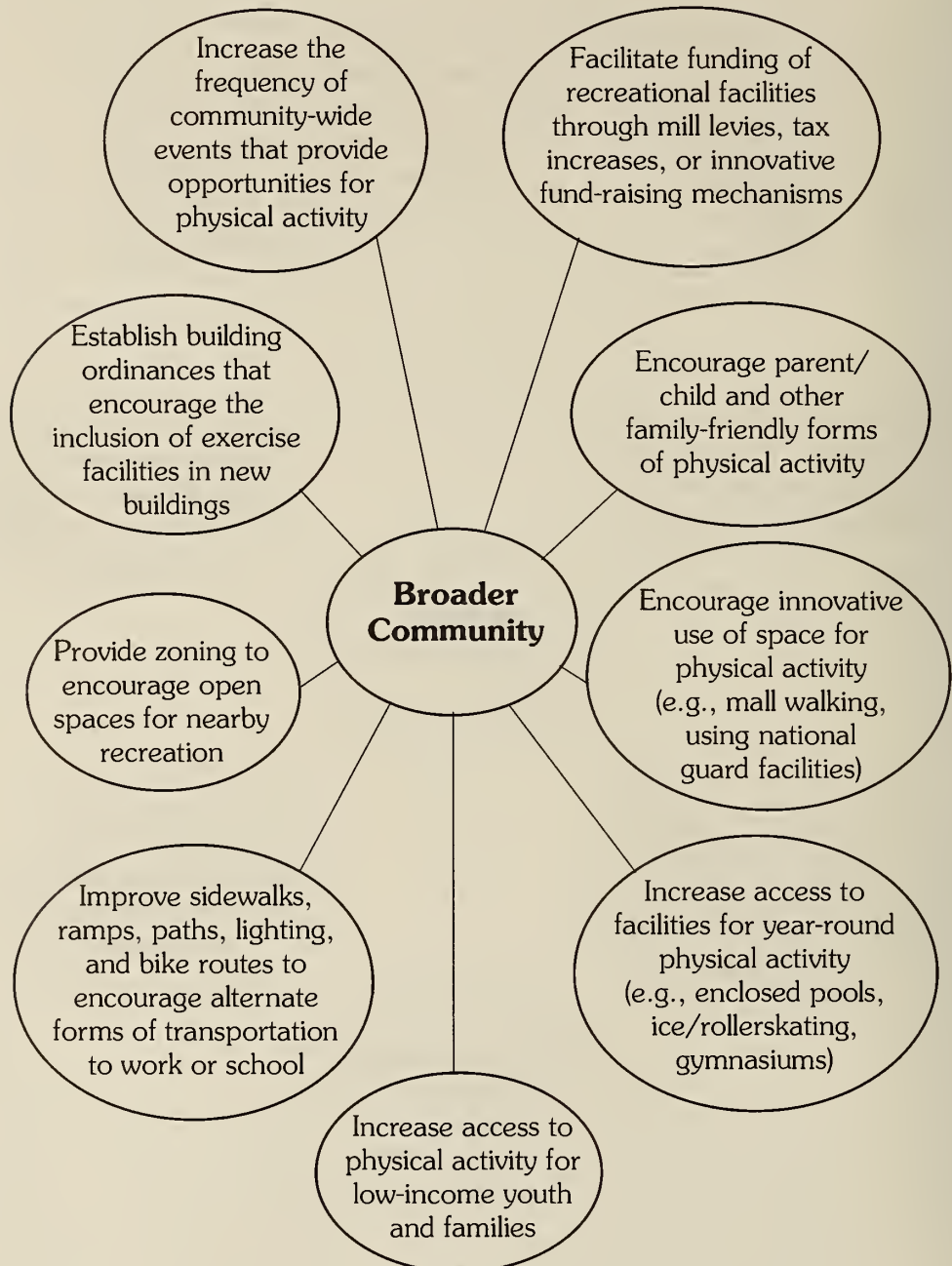


Figure 1.4
Illustrative community changes in the broader community
to increase physical activity



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Evaluating Community Partnerships to Prevent Cardiovascular Diseases: Some Key Questions

Often, community partnerships collect data that are analyzed, filed, and never used. Why? Evaluators may have chosen poor measures of community efforts—measures that do not really capture what made the initiative unique or effective. Perhaps the measures were chosen well but evaluation data were never provided to project staff in a useful and understandable format. When we are involved in efforts to improve the health of our communities, we want to know whether we are achieving what we set out to do. Also, if we are not making progress toward our goal we want to know sooner rather than later so we can change our strategy and begin making progress.

To gain knowledge, we ask questions. The best evaluations answer simple questions that are important to project staff, funders, and community members. Chapter 1 outlined how community coalitions are designed to reduce risks for CVD. These partnerships mobilize community members and resources to make changes in multiple sectors of the community. Community changes reduce risks for CVD by helping community members adopt healthy behaviors. How do you know when an initiative is “working”? Consider posing the following core evaluation questions.

Core evaluation questions

- Was the community mobilized to reduce risks for CVD? (Chapter 4)
- What changes in the community resulted from the initiative? (Chapter 4)
- Is there a change in behavior related to risks for CVD? (Chapter 7)
- Does the initiative have a community-level outcome related to risks for CVD? (Chapter 8)
- Is community-level outcome related to changes facilitated by the initiative? (Chapters 4 and 8)

Funders, community members, and staff of community partnerships may have other questions about the initiative.

Other key evaluation questions

- Were members satisfied with the partnership? (Chapter 5)
- Were the community changes important to reducing risks for CVD? (Chapter 6)
- What critical events seemed to spur rates of community change? (Chapters 4 and 9)

Evaluation questions are designed to provide information on whether community-based programs are making progress toward reducing risks for CVD. Chapters 4–9 in Part II describe how data can be collected to answer evaluation questions.

When deciding what questions to examine, consider:

- What members and leaders of the community partnership want to know.
- Requirements from grantmakers and others about what questions should be addressed.
- Resources available to address these questions.

As recommended in the Preface, for community partnerships with HIGH resources and requirements for evaluation, one might consider addressing all of these evaluation questions and others of interest. By contrast, for community partnerships with LOW resources and requirements, one might address a subset of questions of particular interest.

A Framework for Monitoring and Improving Cardiovascular Disease Prevention Initiatives

This chapter presents the evaluation framework and describes information that might be collected to answer core evaluation questions about community partnerships to prevent and control CVD. Of course, the information actually obtained should depend on the interests, resources, and requirements for the evaluation.

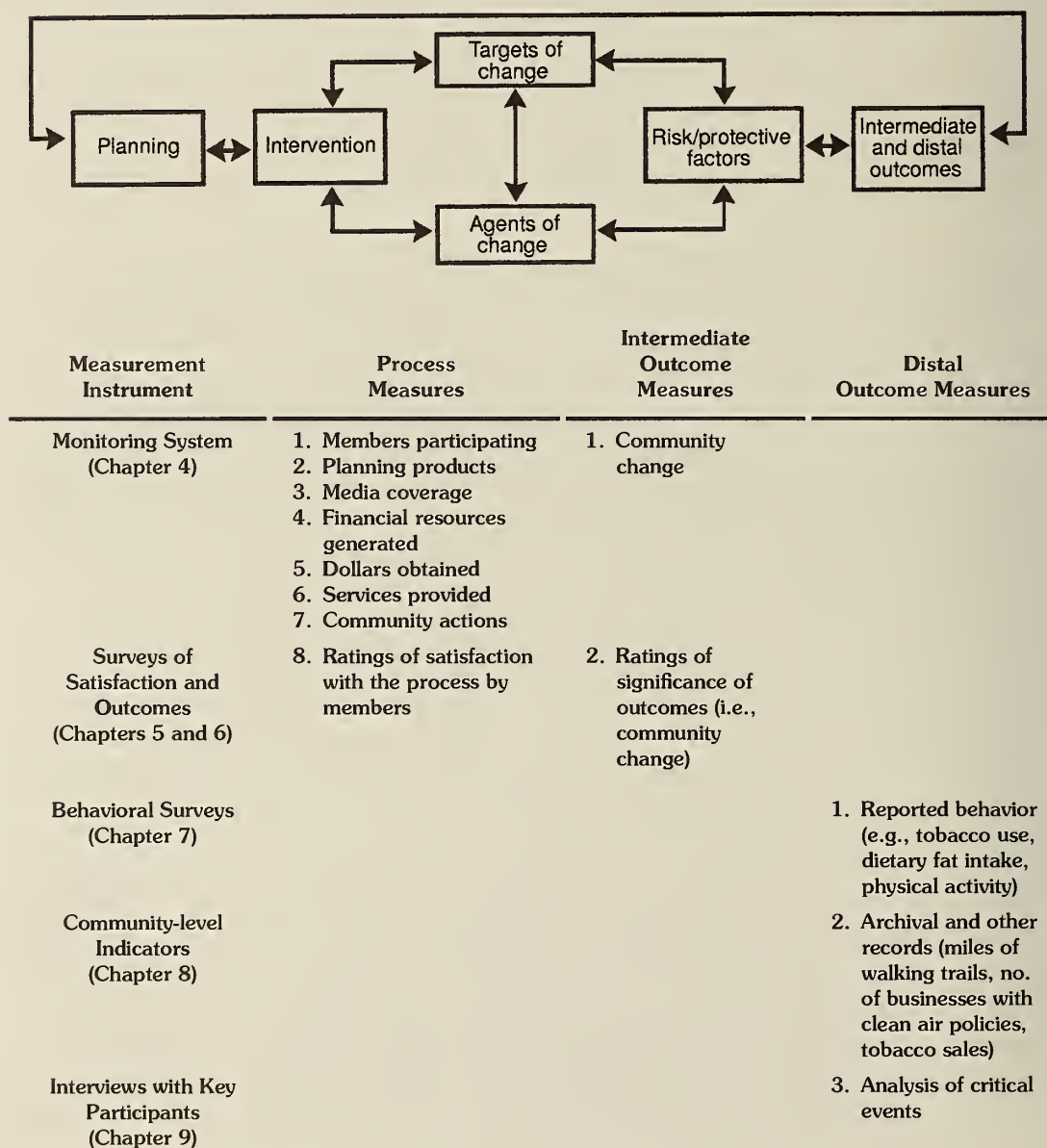
Before the evaluation framework is presented, a note on terminology may be helpful. The language and vocabulary of evaluation is often complex and occasionally inconsistent. For instance, many evaluators trained in health education use the term *process* to refer to those evaluation activities that examine the intervention as it is occurring, *impact* to refer to the direct or immediate effects of an intervention, and *outcome* to refer to the less direct or longer term effects, such as changes in CVD mortality. On the other hand, for many other program evaluators, the terms impact and outcome are reversed, used interchangeably, or modified in other ways. For the evaluation system presented in this manual, we refer to immediate or short-term effects as *intermediate outcomes* and longer-term effects as *distal outcomes*. This terminology conveys the concept that changes occur over time, with intermediate changes generally leading to changes that are farther along or more distal to the initiation of programs. Thus, we evaluate the sequence of activities that may be of interest to community-based CVD prevention initiatives in terms of *process*, *intermediate outcomes*, and *distal outcomes*.

This system for evaluating CVD prevention initiatives is linked to a conceptual framework¹ for promoting health through community development. We have found it useful to describe initiative development in four phases: (a) *planning*, in which a vision, mission statement, objectives, strategies, and action plans are developed; (b) *intervention*, in which staff and membership take action in relevant sectors of the community to influence the behaviors of targets and agents of change; (c) *monitoring of intermediate outcomes*, such as changes in the community to reduce risks and enhance protective factors for CVD; and

(d) *monitoring of more distal outcomes*, such as reported physical activity and archival records of tobacco sales.

The top part of Figure 3.1 shows the relationship among the phases and components for developing community partnerships. Recommended evaluation measures for each phase are listed below the diagram.²

Figure 3.1
Framework for evaluating and
improving community partnerships to prevent CVD



The evaluation measures are described in terms of *process*, *intermediate*, and *distal outcomes*. Process measures correspond to the planning and intervention phases of the initiative; these measures collect data on whether the initiative completed planning and is operating according to plans. Intermediate outcomes assess changes in the environment corresponding to risk reduction; these measures are used to collect data on whether the initiative has facilitated new programs, policies, and practices (community change) consistent with the mission of preventing CVD. Distal outcome measures correspond to whether the initiative has changed behavior associated with risks for CVD and other community-level indicators associated with reduced incidence and prevalence of CVD.

Table 3.1 summarizes the measurement instruments used in tracking process, intermediate, and distal outcomes. The following sections briefly describe each measurement instrument, the types of information collected using each instrument, and the evaluation question(s) the instrument is designed to address.

Measurement Instruments

Monitoring System

The monitoring system is designed to provide information on the activities of initiative staff and members. These activities are analyzed to determine which have resulted in new programs, policies, or practices (community changes). Community changes and other project activities are graphed and periodically provided to project staff. Community leadership collect data for the monitoring system, and they also communicate the data to their membership and funding partners. Measures from the monitoring system can help answer the evaluation questions: “*Was the community mobilized to address the mission?*” and “*What changes in the community resulted from the initiative?*”

Table 3.1
System for evaluating community partnerships to prevent CVD

Measurement Instrument	Measures and Brief Definitions
Process Evaluation	
<i>Monitoring System</i>	<ol style="list-style-type: none"> 1. Members participating: New members, affiliates, or partners of the initiative. 2. Planning products: New objectives, by-laws, committees, and other internal outcomes resulting from planning activities. 3. Media coverage: Instances of coverage by radio, television, and print media (e.g., newspapers and billboards). 4. Financial resources generated: Instances of grants received, donations, in-kind professional services, and other resources received by the initiative. 5. Dollars obtained: Dollar amount of grants and other monies received by the initiative. 6. Services provided: Classes, workshops, newsletters, support groups, screenings, or other informational or service programs provided by the initiative for members of the community. 7. Community actions: Actions (e.g., phone calls and personal contacts) taken outside the group to bring about changes in the community related to the initiative's goals and objectives.
<i>Member Satisfaction Survey</i>	<ol style="list-style-type: none"> 8. Satisfaction with aspects of the initiative (e.g., leadership) according to members.
Intermediate Outcome Evaluation	
<i>Monitoring System</i>	<ol style="list-style-type: none"> 1. Community changes: Changes in programs (e.g., new services established), policies (e.g., modified city ordinances), and practices (e.g., enhanced enforcement) of agencies, businesses, and governmental bodies related to the initiative's goals and objectives.
<i>Constituent Survey of Outcomes</i>	<ol style="list-style-type: none"> 2. Significance to the mission of community changes according to members of the initiative and/or outside experts in prevention of cardiovascular diseases.
Distal Outcome Evaluation	
<i>Behavioral Surveys</i>	<ol style="list-style-type: none"> 1. Behavioral measures (e.g., diet, physical activity, and smoking).
<i>Community-level Indicators</i>	<ol style="list-style-type: none"> 2. Community-level indicators (e.g., archival records and other indirect or global measures such as miles of walking trails, percentage of stores with low-fat milk, and tax revenue from tobacco sales).
<i>Interviews with Key Participants</i>	<ol style="list-style-type: none"> 3. Qualitative information about critical events in the initiative's history based on semistructured interviews with key participants.

Monitoring and feedback system

- Process and outcome measures.
- Observational system.
- Regular feedback on performance.

Process and Outcome Measures. Process measures collect information on whether the community partnership completes planning and is operating according to plans. Outcome measures collect information on whether the initiative is making progress toward reducing risks for CVD. Table 3.1 provides brief definitions of eight kinds of information collected by the monitoring system. Process measures include the number of (a) members participating, (b) planning products, (c) instances of media coverage, (d) financial resources generated, (e) dollars obtained, (f) services provided, and (g) community actions. The measure of intermediate outcome collected using the monitoring system is community change. Please review carefully the measures and brief definitions.

Two measures in the monitoring system—community actions and community changes—may be especially valuable for community initiatives. If members of the partnership meet with influential community members or agencies (such as the food service staff of a school cafeteria), they can produce changes in programs, policies, and practices (for example, menu changes to reduce fat in school lunches). These kinds of actions and outcomes may reduce risks and enhance protective factors for CVD (for example, intake of dietary fat among school-aged children). High rates of community action suggest that the project is attempting to create a large number of changes in agencies and organizations. Rates of community change facilitated by the partnership provide the earliest evidence that the group is on the road to reducing risks for CVD.

Collecting Data. Members of the community partnership, usually staff or committee chairpersons, use Event Logs to record monitoring data. Completed Event Logs provide information about (a) the program or objective for which actions were taken, (b) actions (what was done), (c) date of action or outcome (when), (d) target of action (to or with whom), (e) actors' names (by whom), (f) the location of the action (where), and (g) the outcome achieved (change in program, policy, or practice). The logs are scored by those responsible for the evaluation. Evaluators may need to clarify the information and check for completeness.

Those responsible for the evaluation use written definitions of the monitoring measures to categorize activities reported in the logs. (If resources permit, scoring by a second, independent observer permits an assessment of reliability or interobserver agreement.) Once the activities have been categorized, evaluators count up the number of activities adhering to each definition. For example, all log entries that report a change in a program, policy, or practice are *community changes* and are tallied to provide a measure of how much community change occurred as a result of project activities during the reporting period.

Feeding Data Back to Relevant Audiences. Those with evaluation responsibilities graph monitoring data and use the graphs to provide updates on progress. Data are graphed and provided to initiatives on a regular basis. Monitoring data enable collaborators to detect and celebrate early successes, such as a newly established program, that might have required a large number of actions. Because the monitoring system measures many different kinds of activities, the partnership will be able to see how its members and staff are expending effort. For example, a community coalition may be providing large amounts of information and referral but have low rates of community action (meeting with community leaders or agencies to create community change). On the basis of this feedback, the coalition may decide to redirect efforts to increase rates of community action and change.

Partnership staff can use these data in newsletters and reports and in meetings with members and potential funders to promote the initiative or solidify support. Chapter 4 describes the monitoring system in more detail.

Surveys of Satisfaction and Outcome

Surveys help assess satisfaction with the coalition's operations (process) and achievements (intermediate outcome) from the perspective of members and other important audiences. We recommend that evaluators provide reports to leadership and membership of the initiative about members' satisfaction with the initiative-building process and whether achievements of the partnership are likely to reduce risks for CVD.

Constituent surveys

- Satisfaction with process.
- Significance of outcomes.

Survey of Member Satisfaction. At the end of each operating year, we recommend conducting a survey to assess members' satisfaction with the community initiative. Chapter 5 describes this Member Satisfaction Survey in more detail. The satisfaction survey can help answer the evaluation question: *“Were members satisfied with the initiative?”*

Survey of Outcomes. A survey can be used to assess the significance of community changes resulting from the initiative's efforts. Chapter 6 provides more information on the survey of outcomes. The Outcome Survey can help answer the evaluation question: *“Were the community changes important to reducing risks for CVD?”*

Behavioral Surveys

To help guide efforts and to assess distal outcomes of the community partnership, it may be appropriate to obtain and analyze existing data on CVD risk behaviors. For example, relevant modules of the Behavioral Risk Factor Surveillance System (BRFSS) questionnaire can provide important data on whether citizens are changing diet, exercise, or tobacco-related behaviors as a result of initiative efforts. Chapter 7 provides more information about using behavioral surveys. With adequate resources, behavioral surveys can help answer the evaluation question: *“Is there a change in behavior related to risks for CVD?”*

Community-level Indicators

We also recommend using archival records and other indirect or global measures to select and obtain community-level indicators of whether risks of CVD have been reduced. For example, for tobacco control these might include tax data on per capita consumption of cigarettes and smokeless tobacco. If tax revenues decline, it may suggest that the partnership is having an impact on a very important risk factor for CVD. Chapter 8 discusses how to use community-level indicators in detail. Data from community-level indicators can help answer the evaluation question: *“Does the initiative have a community-level outcome related to risks for CVD?”*

Interviews with Key Participants

Finally, we recommend using interviews with active leaders of the community partnership to provide information about the initiative's efforts, achievements, and barriers to success. The interviews are usually conducted several years into the implementation of the initiative or during transitions between leaders. The

focus of the interviews is to identify and analyze critical events in the history of the partnership, such as securing the initial grant or action planning. Chapter 9 offers items about how to identify and explore critical events in interviews with key participants. Interviews with key participants can help answer the evaluation question: *“What critical events seemed to spur rates of community change?”*

Conclusion

The monitoring system tracks many process and outcome measures. It may be the most important part of the evaluation, because it collects data on the short-term effects of initiative efforts (community actions and changes). Through the monitoring system, the initiative gets quick feedback on how well its efforts are paying off in terms of community change. Other aspects of the evaluation use surveys and a variety of other reporting instruments and are designed to assess member satisfaction with the process and outcomes of the initiative, identify behavior change as a result of coalition efforts, determine whether the initiative is having an impact on community-level indicators, and identify critical events in the history of the partnership. The following six chapters present detailed descriptions of each of the six core measurement instruments.

When deciding what measurement instruments to use, consider:

- What members and leaders of the community partnership want to know.
- Requirements from grantmakers and others about what questions should be addressed.
- Resources available to address these questions.

For community partnerships with HIGH resources and requirements for evaluation, consider using all of these tools for evaluating community partnerships and others of value. This might presume the availability of coalition staff to provide information, a person with basic skills in evaluation, and a modest budget specifically for expenses related to the evaluation.

For community partnerships with LOW resources and requirements, consider using only a few of these measurement instruments. This might presume little or no evaluation budget and virtually no reporting requirements. Staff might be available for evaluation activities for several hours a week or less, with minimal training in evaluation. Recommended instruments to be used by community

partnerships with minimal resources and requirements follow. This list may be modified based on the community partnership's interests, requirements, and resources for evaluation.

Recommended Measurement Instruments and Time Estimates^{*}

- Monitoring system (Chapter 4): Approximately 15 hours per month if only community change is measured on an ongoing basis.
- Survey of satisfaction (Chapter 5): Approximately 10 hours annually.
- Survey of outcomes (Chapter 6): Approximately 15 hours annually.
- Behavioral survey (Chapter 7): Approximately 20 hours if data are available.
- Community-level indicators (Chapter 8): Approximately 20 hours, only if data are available from other sources, annually.
- Interviews with key participants (Chapter 9): Approximately 30 hours every 2 years.

^{*}Based on experience with a variety of partnerships for community health and development. Time estimates may vary depending on the need for negotiation of instruments, number of individuals you wish to collect data from, technology available to analyze data, reporting requirements, and experience implementing data collection systems.

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PART II

The Evaluation System

What's Ahead . . .

- ❖ Monitoring System
- ❖ Assessing Member Satisfaction
- ❖ Assessing the Importance of Outcomes
- ❖ Using Behavioral Data and Surveys
- ❖ Community-level Indicators of Cardiovascular Health
- ❖ Conducting Interviews with Key Participants

Process Measure	Intermediate Outcome Measure	Distal Outcome Measure
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Monitoring System

Monitoring data contribute information about the *process* and *intermediate outcomes* of community partnerships. Logs and interviews with those most involved in the partnership are used to gather data. Several core evaluation questions may be addressed using data from the monitoring: (a) Was the community mobilized to reduce the risks for CVD? (b) What changes in the community resulted from the initiative? (c) What critical events seemed to spur rates of community change? and (d) Are community-level outcomes related to changes facilitated by the initiative?

Monitoring system: What and why?

What is it?

- A way of tracking major events and accomplishments.

Why use it?

- To understand the initiative.
- To decide where to focus efforts.
- To promote awareness of accomplishments.
- To recruit support.
- To secure grants.

Monitoring data help detect how initiatives use resources. For instance, if the purpose of the coalition is to serve as a catalyst, high rates of community change, rather than provision of direct services, may be particularly valued.

Monitoring data also point out the community sectors that are more engaged. For example, are most changes occurring in worksites with fewer changes in schools? These data enable partnerships to determine which strategies, risks, and protective factors are being addressed. For example, for a tobacco control effort, is lots of information being provided with few changes that modify access to products such as tobacco? Staff and leadership can use monitoring data to promote community awareness of the initiative's early successes, recruit community support, and secure financial resources.

To monitor the major events and accomplishments of the collaborative partnership, use recording sheets, called log forms, and interviews with people completing the monitoring log forms. Although these will vary with each initiative, important events may include services provided; instances of media coverage; resources generated; community actions; and changes in programs, policies, and practices (community changes) related to the mission of reducing the risks for CVD.

Monitoring System — The Five Steps

This chapter describes how to use the monitoring system to collect important events and other data relevant to community initiatives for reducing the risks for CVD.

Monitoring system: How to's

- Complete log forms.
- Clarify log entries.
- Categorize log entries.
- Assess reliability of scores (optional).
- Graph data and provide feedback.

There are five major steps in the monitoring process. First, key participants, such as active members of the coalition and project staff, describe the project's activities on record sheets (log forms). Second, the entries are clarified, if necessary. Third, someone scores the reported activities into different categories using a set of definitions. Fourth, someone else also categorizes the

reported activities to obtain an estimate of the accuracy or reliability of the first categorization (optional). Finally, the cumulative number of events from each different category is graphed. The graphs are then shared with key participants and the community at large. The next sections outline these five steps.

Keep in mind that monitoring is one of the most complicated processes described in this handbook. The last three steps (categorizing log entries, assessing reliability, and graphing and providing feedback) may require additional training to complete. Those responsible for monitoring coalition activities may consult the background information in Appendix A for additional instructions, examples, and practice exercises. The background information and materials provide more detailed instruction for using the monitoring system outlined in the following five steps.

Step 1: Complete Log Forms

Materials needed: Blank log forms (in Appendix A)

Time required: Up to 2 hours per week

Who does it? Active members of the partnership and staff

Information to complete log forms can be gathered in a number of ways. Many community partnerships have staff and active members complete log forms on a monthly basis. Some groups complete log forms during committee or staff meetings—log forms then serve as meeting notes as well as provide information for the evaluation. Some staff members complete log forms by reviewing their calendars, meeting minutes, and newspaper articles that report on the group's activities.

A number of different log forms have been developed to gather different types of information. *Event Logs* are used to record activities that have the goal of making systems or community changes. Community changes are changes in programs, policies, or practices designed to reduce the risks for CVD. Individuals completing the Event Logs are asked to describe the event in detail, including providing information on (a) why the event is important, (b) what happened as a result of the event, (c) who was involved, (d) what organizations were collaborators, (e) what objective or sector of the community the event is related to, and (f) whether this was the first time the event happened. Answers to these questions help determine what category the event fits into (see Step 3: Categorize Log Entries).

Many initiatives want information about other important activities of the group. The *Ongoing Services Provided Log* gathers information about educational or service programs provided by the group. Smoking cessation classes, presentations describing the project, and mall walking clubs established for

seniors in the community are all examples of services that could be provided by an initiative to reduce risks for CVD. Many groups are interested in tracking how much media attention they receive, which is the purpose of the *Media Coverage Log*. The *Resources Generated Log* tracks both in-kind and monetary resources secured by the initiative.

Four log forms have been described: Event Log, Ongoing Services Provided Log, Media Coverage Log, and Resources Generated Log. Examples of these forms may be found in Figures 4.1–4.4. These sample logs have been filled out with examples of events, ongoing services, media, and resources obtained to show how each could be used by a CVD prevention effort.

Why are there so many log forms? Each of the forms is designed to collect information that is needed to categorize the partnership's activity according to a set of definitions. The categorized information, rather than an unorganized list of the group's activities, is more manageable. It helps answer core evaluation questions more efficiently.

Step 2: Clarify Log Entries

Materials needed: Completed log forms

Time required: Up to 1 hour per month

Who does it? Project staff, internal or external evaluators

Log entries are sometimes incomplete or require additional explanation. Reported events should be complete enough so that someone who is unfamiliar with the organization could understand them. Clarifying logs often requires conversation (in person or through phone calls) between the person who completed the log form and the person who is going to categorize the activities reported in the log. This step is especially important if someone external to the project, such as outside evaluators, categorizes the log entries.

Figure 4.1
Sample Event Log

Site: Anytown

Recorder: Randy T.

Using this form, describe 1) actions taken to bring about changes in the community that are related to reducing risks for cardiovascular diseases and 2) changes in *programs* (e.g., new after-school physical fitness activities), *policies* (e.g., worksite cafeteria offers at least one heart healthy alternative), and *practices* (e.g., labeling heart healthy foods at a local supermarket) that are related to reducing risks for cardiovascular diseases.

Code	Date (m/d/y)	Event	Description
			a. Who was involved? b. What organizations were collaborators? c. What community sector or objective is this related to? d. Was this the first time this event happened?
Community Action (CA)	7/12/93	Meeting to plan the development of low-fat school lunch menus/recipes	a. School food service personnel and initiative staff b. School system and CVD initiative c. Schools d. Yes
Community Change (CC)	7/29/93	Labeling of low-fat items begun in deli and bakery of a local supermarket chain	a. Supermarket manager and initiative staff b. Anytown Supermarket and CVD initiative c. Businesses d. Yes
Community Action (CA)	8/3/93	Met with store executives to determine how to set up reduced price coupons for low-fat salad dressing	a. Supermarket manager and initiative staff b. Anytown Supermarket and CVD initiative c. Businesses d. No
Community Change (CC)	8/24/93	Implemented employee health fair including cholesterol screening and incentives for lowering serum cholesterol	a. Health and Wellness manager and initiative staff b. Adams Factory c. Business d. Yes

Send this form by the first Friday of every month to the evaluators: _____

Figure 4.2
Sample Ongoing Services Provided Log

Site: Anytown

Recorder: Ralph M.

Using this form, describe classes, workshops, screenings, or other informational or service programs provided to community members on a regular basis. Note whether this is the first time that this service has been provided in the community.

Code	Date (m/d/y)	Service (e.g., workshop, class, screening)	Location of Service	No. of people attending	No. of hours	New Service? Yes/No
Service Provided	8/21/93	Presented Fat Tubes display (relative amounts of fat in foods) at the county 4-H fair	4-H fairgrounds	300	15	Yes
Service Provided	9/3/93	Gave presentation on prevention of cardiovascular diseases to the local Rotary club	Rotary club meeting	15	1	No
Service Provided	9/2/93	Formed walking clubs; established for seniors	Unity Church	25	1	No
Service Provided	9/20/93	Tips on preventing CVD were printed and distributed on grocery sacks all month	Supermarket chain	approx. 12, 000	—	Yes
Service Provided	9/23/93	Cook-off was held with AME Church featuring low-fat, high-fiber, ethnic foods	AME Church	150	3	No

Send this form by the first Friday of every month to the evaluators: _____

Figure 4.3
Sample Media Coverage Log

Site: Anytown		Recorder: Sally F.	
MEDIA COVERAGE Please attach copies of newspaper articles, etc.			
Date (m/d/y)	Topic of Media Coverage (e.g., announcing a new program)	Media Type (e.g., newspaper, TV, radio)	No. of Newspaper Column Inches or Broadcast Minutes (e.g., 4 inches, 2 minutes)
8/1/93	Initiative Press Conference and Kick-off Rally	Radio and TV	4 minutes on local evening news (3 stations)
9/2/93	PSA on exercise and CVD released and aired	TV	6 PSAs, 30 seconds each
9/24/93	Article about local restaurants with heart healthy menus	Newspaper	5 column inches
Send this form by the first Friday of every month to the evaluators: _____			

Figure 4.4
Sample Resources Generated Log

Site: Anytown

Recorder: Sally F.

RESOURCES GENERATED Include cash and grants (e.g., United Way grants and Rotary cash donation) and in-kind donations (e.g., free professional service and food donation).			
Date (m/d/y)	Source	In-kind Dollar Amount	Cash/Grants Amount
8/3/93	Pizza, Inc. (pizza with low-fat cheese for classes in health education)	\$85.00	—
9/21/93	Grant from local health department to consult with child care providers on improved menus for children	—	\$10,000

Send this form by the first Friday of every month to the evaluators: _____

Step 3: Categorize (Score) Log Entries

Materials needed: Completed and clarified log forms

Time required: 1–2 hours per month

Who does it? Project staff, internal or external evaluators

Additional instructions, examples, and practice exercises are provided in the background information in Appendix A

This step is the most important, and most difficult, part of the monitoring system. In this step, definitions are used to categorize log entries. Entries on the log forms are compared to definitions and categorized according to which definition best describes the event. Scoring can be done by a project staff member, internal evaluator, or external evaluator.

The categories for scoring are as follows: *Community actions, community changes, planning products, services provided, media coverage, and resources generated*. Brief definitions of each type of event are provided in Table 4.1. Complete instructions for coding and expanded definitions are given in the background information in Appendix A.

Scoring log entries is sometimes difficult and requires practice. Using log forms, such as the Event Log provided at the end of this chapter, is helpful because the form requests information needed to assign a category to each event. Entries in the Event Log typically will be assigned the scoring category of *community action, community change, or planning products*. Scores for entries on the Ongoing Services Provided Log, Media Log, and Resources Obtained Log will often be more straightforward. Entries should be reviewed carefully, however, to make sure they match the definitions of *services provided, media coverage, resources generated, and other*.

Table 4.1
Types of community partnership activities,
their definitions, and examples of log entries

Type of partnership activity	Definition	Example
Community Actions	Actions taken in the community to bring about a new or modified program, policy, or practice to reduce risks for CVD	Memorandum of agreement between the Church League and City Parks and Recreation Department to sponsor summer fitness clubs for adolescents
Community Changes	New or modified programs, policies, or practices in the community facilitated by the initiative that reduce risks for CVD	<p><i>Programs:</i> Established new physical fitness programs for older adults (physical activity); all county physicians and other health care providers began assessing and counseling all patients on smoking, diet, and physical activity (tobacco, diet, physical activity)</p> <p><i>Policies:</i> Adopted ordinance that would rescind license of merchants that sell tobacco to minors (tobacco); adopted policy requiring lower fat school lunches (diet); established a policy allowing flexible work hours to accommodate exercise (physical activity)</p> <p><i>Practices:</i> Businesses refused to provide free samples of tobacco (tobacco); local media provided free advertisement for restaurants that offer lower fat entrees (diet); parks and recreation department offered activities for youth and families of low income (physical activity)</p>
Planning Products	The results or products of planning activities within the group	Hiring of staff; mission statement developed; strategic plan adopted; guidelines developed for awarding minigrants; committee formed; grant application completed
Services Provided	Events that are designed to provide information or instruction or to develop skills of people in the community	Class held; workshop conducted; presentation to Rotary; displays of project at 4-H fair, media campaign using physical activity guidelines recommended by CDC

Table 4.1
Types of community partnership activities,
their definitions, and examples of log entries (Continued)

Type of partnership activity	Definition	Example
Media Coverage	Coverage of the initiative or its projects in the newspaper, radio or television, or newsletter	KJHK aired 30 public service announcements (PSAs) (15 minutes total) describing risk factors for CVD
Resources Generated	Acquisition of funding for the initiative through grants, donations, or gifts in-kind	\$2,500 of donated goods secured for Health March and Rally; \$10,000 grant

This method of categorizing log entries is actually a measurement system. It allows community partnerships to sort their efforts into types of activities. Once actions are categorized (Step 3) and graphed (Step 5), the initiative can get a clearer idea of how much effort it is expending in different types of activities.

Step 4 (optional): Assessing Reliability (Agreement on Scoring)

Materials needed: Scored log forms, formula for calculating reliability (Appendix A) or computer program for calculating reliability

Time required: 1–2 hours per month

Who does it? Project staff, internal or external evaluators

Additional instructions, examples, and practice exercises are provided in Appendix A

Some people will be skeptical of the codes assigned to the log entries. How do they know the entries were put in the correct categories? To address these concerns, another person can score the same set of logs. The two scores are compared, thus providing an estimate of reliability. Reliability scores can be obtained by calculating with a computational formula manually or by using a statistics computer program. Complete instructions for assessing reliability are provided in the background information section in Appendix A. Partnerships with minimal resources and requirements for evaluation might not be expected to assess reliability.

Step 5: Graphing and Using the Data

Materials needed: Scored log forms, data from previously completed logs, graph paper or computer graphing program

Time required: 1–3 hours per month

Who does it? Project staff, internal or external evaluators

Additional instructions, examples, and practice exercises are provided in Appendix A

Filling out and scoring logs takes time. What are the results? Once log items are categorized or scored, the number of items in each category, such as community change, community action, or planning products, can be graphed. Data presented in this way will help projects compare how much effort they are spending in different areas. The graph can be shared monthly or quarterly with project staff, leadership, membership, funders, and partners of the initiative. A sample graph is shown in Figure 4.5. Instructions for constructing graphs and providing feedback on the data are included in Appendix A.

Figure 4.5
Sample feedback graph of community changes



Community changes are new programs, policies, or practices in the community that are produced by project members and are relevant to the initiative's goals.

Examples of community changes produced by the county include:

- Comprehensive tobacco control curriculum implemented in YWCA after-school programs.
- Cooks at Happy Corner day care were trained in preparing menus and foods to meet nutritional guidelines.
- The company, PackSac, added a gym to its new plant and began offering incentives for employees to stay fit.

Patterns to notice:

There has been a steady rate of community changes produced since January 1994 when the director was hired. Four new programs were established in February 1995.

Adjusting the System to Meet Your Needs

When deciding what data to collect with the monitoring system, consider:

- What members and leaders of the community partnership want to know.
- Requirements from grantmakers and others about what questions should be addressed.
- Resources available to address these questions.

The amount of time and resources needed to monitor a CVD prevention effort will vary depending upon a variety of factors. Of course, monitoring activities can be prioritized and tailored to match the requirements of the evaluation and resources available to carry it out.

Recommended Monitoring System for Those Operating on a Shoestring Budget

- Collect, graph, and provide quarterly feedback on community change only (using the Event Log only).
-
-

Process Measure	Intermediate Outcome Measure	Distal Outcome Measure
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Assessing Member Satisfaction

Surveys can be used to assess satisfaction of members of the coalition with the functioning of the partnership. These surveys help examine the *process* of the initiative, an important aspect of the framework for evaluation described in Chapter 3. Specific survey questions may address a variety of areas, including planning, leadership, services, community involvement, and progress toward accomplishing goals. Such surveys help address a key evaluation question: *“Were constituents satisfied with the initiative?”*

Survey of satisfaction: What and why?

What is it?

- A survey to assess members' satisfaction with the functioning of the initiative.

Why do it?

- To inform the partnership about strengths and weaknesses from the perspective of coalition members or constituents.
- To identify issues that could become potential problems.

The satisfaction survey allows members of the partnership to give feedback to leadership on how well the initiative is doing. Data from the survey helps identify strong and weak features of the initiative. The survey also permits issues to be dealt with early on before they escalate into problems.

This section describes how to obtain ratings of members' satisfaction with the initiative by using the survey.

Satisfaction survey: How to's

Develop a survey to assess member satisfaction with:

- Planning and implementation.
- Leadership.
- Services.
- Community involvement with the initiative.
- Progress and outcome.

Obtain ratings from members of the coalition or project.

Use the data to improve the functioning of the initiative.

Those responsible for the evaluation help design the survey process in collaboration with leadership of the partnership. Questionnaires are distributed (usually by mail) to members of the initiative. Completed questionnaires are returned by mail (or drop box) to preserve the members' anonymity. Data from questionnaires are entered and summarized. Results are provided to the staff and membership of the coalition or project.

This survey should be done annually. The entire process from beginning to end usually takes approximately three months. Leadership of the project spend approximately five hours or less developing questions and distributing the questionnaires.

Adjusting the System to Meet Your Needs

A complete generic satisfaction survey for a coalition to reduce risks for CVD is at the end of this chapter. A sample cover letter and a sample memorandum of results are also included.

When deciding what to ask members about, how often to ask, and by what means to gather information, consider:

- What members and leaders of the community partnership want to know.
- Requirements from grantmakers and others about what questions should be addressed.
- Resources available to address these questions.

For community partnerships with HIGH resources and requirements for evaluation, consider doing annual (or even more frequent) assessments of member satisfaction. This might presume the availability of coalition staff to print and distribute questionnaires; a person with basic skills in data entry and analysis; and a modest budget for printing, distribution, data analysis, and other related expenses.

For community partnerships with LOW resources and requirements, consider assessing member satisfaction informally or less often. This might presume little or no evaluation budget and virtually no reporting requirements. Staff might be available for one day or less, with minimal secretarial support for data entry.

**Recommended Strategies for Assessing Member Satisfaction
on a Shoestring Budget**

- Distribute surveys at coalition meetings. Use a calculator to summarize the data on member satisfaction. If time allows, review and summarize the data at the end of the meeting.
 - Include a limited number of questions in a coalition newsletter or other planned mailing. Ask members to donate the returned postage.
 - Collaborate with a local community college or university that conducts the survey as part of a class project.
 - Instead of using a survey, collect information in informal listening sessions. Flip charts, a writing board, or chalk board, or plain paper can be used to capture member input on:
 - Issues
 - Barriers
 - Resources
 - Alternative solutions.
 - Local organizations, such as the League of Women's Voters or Junior League, might facilitate these kinds of listening sessions free of charge.
-
-

Materials for Assessing Member Satisfaction

The following section provides a sample member satisfaction survey and other background information. Materials that can be tailored to suit any CVD prevention effort planning to do a Member Satisfaction Survey are included.

The following are included

- A sample cover letter for a satisfaction survey (Figure 5.1) that describes the survey's purpose, how it should be filled out, and what will be done with the results.
- A format for a generic survey (Figure 5.2) outlining the components and suggested format that can be used as a guide when developing a member satisfaction survey.
- An example memorandum (Figure 5.3) that describes how the results of the member satisfaction survey can be summarized and presented. This document may be used by a partnership to communicate information about the results.

Figure 5.1
Sample cover letter for the Member Survey of Satisfaction

Date

Dear Member of (the initiative):

The purpose of the attached member satisfaction survey is to get your feedback on how well (the initiative) is doing in implementing its goals. As you know, (the initiative's) mission is to _____ in (city/county/state).

Please complete each question by circling the number that best shows your satisfaction with that aspect of the initiative. Your comments and suggestions on how to improve (the initiative) are welcome.

To protect anonymity, use the enclosed envelope to return your completed questionnaire to our evaluators, the (name them).

Thanks in advance for your valuable time and feedback.

Best regards,

Executive Director

Enclosure

Figure 5.2
Generic Member Survey of Satisfaction

PLEASE RETURN TO _____ (return address)

PLEASE RETURN BY _____ (due date)

(Date)

We appreciate your comments on how well (the initiative) is doing. Please provide your suggestions for improving the initiative and describe the things with which you are most pleased. For each item, please circle the number that best shows your satisfaction with that aspect of the initiative. Provide additional comments if you wish.

Planning and Implementation:	Very dissatisfied			Very satisfied	
	1	2	3	4	5
1. Planning process used to prepare the objectives for the coalition.					
2. The objectives selected.					
3. Follow through on activities.					
4. Competence of staff.					

Comments:

Leadership:

5. Clarity of the vision for where the initiative should be going.	1	2	3	4	5
6. Strength and competence of leadership.	1	2	3	4	5
7. Sensitivity to cultural issues.	1	2	3	4	5
8. Use of the media to promote awareness of the project's goals, actions, and accomplishments.	1	2	3	4	5
9. Opportunities for members to take leadership roles.	1	2	3	4	5

Comments:

Services:	Very dissatisfied			Very satisfied	
	1	2	3	4	5
10. Quality of the services provided, sponsored, or initiated by the initiative.					
11. Quantity of the services provided, sponsored, or initiated by the initiative.	1	2	3	4	5
12. Training and technical assistance.	1	2	3	4	5
13. Fund-raising and grantwriting.	1	2	3	4	5
14. Information and referral.	1	2	3	4	5
15. Advocacy.	1	2	3	4	5

Comments:

Community Involvement in the Initiative:

16. Extent to which members of the community participated in the planning.	1	2	3	4	5
17. Extent to which members of the community participated in the implementation.	1	2	3	4	5
18. Extent to which members of the community participated in the programs.	1	2	3	4	5
19. Participation of influential people from key sectors of the community.	1	2	3	4	5
20. Participation of people at most risk for CVD.	1	2	3	4	5
21. Diversity of membership of the initiative.	1	2	3	4	5

Comments:

Progress and Outcome:	Very dissatisfied			Very satisfied	
	1	2	3	4	5
22. Progress in meeting the objectives.	1	2	3	4	5
23. Success in generating resources.	1	2	3	4	5
24. Fairness with which funds and opportunities are distributed.	1	2	3	4	5
25. The initiative's contribution to the goal of reducing intake of dietary fat.	1	2	3	4	5
26. The initiative's contribution to the goal of increasing physical activity.	1	2	3	4	5
27. The initiative's contribution to the goal of preventing/reducing tobacco use.	1	2	3	4	5
28. The initiative's contribution to the goal of (list other major goals if appropriate).	1	2	3	4	5

Comments:

Overall Approval Rating:

- | | | |
|--|-----|----|
| 29. Is the community better off today because of (the initiative)?
(Circle one) | Yes | No |
|--|-----|----|

Overall Comments:

Figure 5.3
Sample memorandum of results for the
Member Survey of Satisfaction

Date: _____

To: (Leadership and Steering Committee)

From: The Evaluation Team

Re: Results of the Annual Member Satisfaction Survey for (the initiative).

Enclosed please find the results of the Annual Member Satisfaction Survey. We had a good response—X of X people (%) completed the survey. This report includes the average rating and the range of responses for each question, and a summary of the comments for each section.

Generally, those members who responded were satisfied with many aspects of coalition functioning outlined in the survey. The range of responses was from 3 to 5 for each issue. The highest ratings were noted for the strength of competence of staff, the strength and competence of leadership, and the clarity of the vision for the initiative. The lowest rating was noted for item 25, the group's contribution to the goal of reducing intake of dietary fat. Ninety-three percent of the respondents felt that the community was better off today because of (the initiative).

Many of the respondents also provided comments at the end of each section. The comments, in addition to the ratings of each question, may provide some helpful feedback in planning for future activities of (the initiative).

If you have any questions, please feel free to call us. We can also further discuss the survey findings at our next meeting.

cc: Program Officer, Funding Source

Process Measure	Intermediate Outcome Measure	Distal Outcome Measure
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Assessing the Importance of Outcomes

Not all changes made by the initiative are equally important. The survey of outcomes asks those involved in the initiative, funding agents, and outside experts to rate the significance of changes that the initiative has made to reduce the risks of CVD. Consistent with the evaluation framework outlined in Chapter 3, it helps assess *intermediate outcomes* for the initiative. A key evaluation question is addressed by this survey: “*Were the community changes important to reducing risks for CVD?*”

Survey of outcomes: What and why?

What is it?

- A way to assess the significance of the community changes facilitated by the partnership.

Why do it?

- To help identify the more important accomplishments of the initiative.
- To direct attention to more valued changes to be sought.

Both members of the partnership and outside experts can assess the importance of accomplishments. Outside experts may include physicians, epidemiologists, national activists in physical activity, tobacco control, or other risk factors, and experts in designing programs to prevent CVD.

The survey asks respondents to rate the contribution of all the changes individually and, taken together, to reducing risks for CVD. Leaders can use these data to adjust the focus of efforts to areas that are valued by people involved and to areas that contribute most substantially to reducing risks for CVD.

This chapter outlines how to use a survey of outcomes to assess the importance of community changes facilitated by the initiative.

Survey of outcomes: How to's

- Develop a survey that lists all community changes (accomplishments) facilitated by the initiative.
- Conduct the survey with:
 - Members (with experiential knowledge of the partnership)
 - Funders
 - Outside experts (with specialized knowledge in community efforts to prevent CVD).
- Obtain average ratings for each change on its significance to reducing risks for CVD.
- Use the survey data to redirect efforts of the initiative.

Evaluators, or persons responsible for conducting the survey, design the survey from a list of the initiative's accomplishments provided by staff or active members. The list of accomplishments can be obtained by using community changes identified with the monitoring system (see Chapter 4). The survey items should acknowledge groups and people who helped make the changes happen. Project staff develop a list of people to receive the survey. The survey is distributed by mail or during coalition meetings. Respondents return completed questionnaires to the evaluation team, who then summarizes the data.

The entire process (from developing the survey to final summarizing of the data) will take about two to three months. Staff of the initiative spend approximately 10 hours in collaborating on developing the survey and distributing questionnaires. We recommend that the outcome survey be conducted every several years and/or in the last year of the grant.

Materials at the end of this chapter include a generic outcome survey that may be used as a format for designing the survey, a sample cover letter, and a sample memorandum of results.

Adjusting the System to Meet Your Needs

When deciding how to assess the importance of outcomes, consider:

- What members and leaders of the community partnership want to know.
- Requirements from grantmakers and others about what questions should be addressed.
- Resources available to address these questions.

For community partnerships with HIGH resources and requirements for evaluation, consider doing annual assessments of the significance of community changes facilitated by the partnership. This might presume the availability of coalition staff to print and distribute approximately 100 questionnaires; a person with basic skills in data entry and analysis; and a modest budget for printing, distribution, data analysis, and other related expenses.

For community partnerships with LOW resources and requirements, consider assessing the importance of community changes informally or less often. Recommended strategies for assessing the importance of outcomes on a shoestring budget are listed below.

Recommended Strategies for Assessing the Importance of Outcomes on a Shoestring Budget

- Distribute the survey only to coalition members, and do so at coalition meetings. If resources permit, consider sending questionnaires to the few constituents the coalition would most like to hear from. Summarize the data on perceived contributions of the community changes to reducing the risks for CVD.
 - Ask persons from local or State health departments who are not involved with the initiative to serve as experts in assessing the importance of outcomes.
 - Instead of using a survey, collect information in informal listening sessions. Flip charts, a writing board or chalkboard, or plain paper can be used to capture member input on:
 - More significant changes in programs, policies, and practices
 - Less significant changes
 - Adjustments in goals to improve outcomes.
 - Local citizen organizations might facilitate listening sessions free of charge.
-
-

Materials for Assessing the Importance of Outcomes

The following section provides a sample survey of outcomes and other background information. Materials that can be tailored to suit any CVD prevention effort that plans to assess the importance of its accomplishments are included.

Materials include the following

- A sample cover letter for an outcome survey (Figure 6.1) that is sent out with the survey and describes the purpose of the survey, how the survey should be filled out, and what will be done with the results.
- A format for a generic survey (Figure 6.2) outlining the components and suggested format that can be used as a guide when developing your Survey of Outcomes.
- An example memorandum (Figure 6.3) that demonstrates how results of a Survey of Outcomes can be summarized and presented. Typically, community partnerships use this or some similarly written document to inform interested parties of the survey results.

Figure 6.1

Sample cover letter for the Outcome Survey

Date

Dear Members of (the initiative):

The purpose of the attached outcome survey is to get your feedback on the accomplishments of (the initiative). As you know, the mission of (the initiative) is to reduce the risks of heart disease in (city/county/state). This survey lists each change in program, policy, or practice facilitated by (the initiative). Note that many of these changes were facilitated in collaboration with partners of (the initiative).

Please complete each question by circling the number that illustrates how *important* each community change is to the mission of reducing risks for CVD.

Once we receive all the completed questionnaires, we will analyze and summarize the data. The results should help identify the accomplishments of the most and least importance from the perspective of coalition members and outside experts in prevention of CVD.

To protect anonymity, use the enclosed self-addressed envelope and return your completed survey to our evaluators, (name them).

Thanks in advance for your valuable time and feedback.

Best regards,

Executive Director

Enclosure

Figure 6.2
Generic Outcome Survey

PLEASE RETURN TO _____ (return address) _____

PLEASE RETURN BY _____ (due date) _____

(Date)

Staff and members of (the initiative) have been involved in efforts that resulted in a variety of community changes related to the mission of preventing CVD.

This survey lists XX community changes that were facilitated or supported by the initiative's efforts. For each survey item, please circle the number that best describes how important each community change is to the initiative's mission of reducing risks for CVD. Use the following scale to rate your answers.

1	2	3	4	5
Very unimportant	Unimportant	Neither unimportant nor important	Important	Very important

	IMPORTANCE to the mission of reducing risks of cardiovascular diseases
--	---

Community Changes	Very unimportant	Very important
------------------------------	-----------------------------	---------------------------

1) (_____ (Date) _____)

2) (_____ (Date) _____)

1	2	3	4	5
---	---	---	---	---

Comments:

<p>Taken together, how important are the above community changes in accomplishing the mission of reducing risks for CVD?</p>	1	2	3	4	5
--	---	---	---	---	---

Figure 6.3
Sample memorandum of results for the Outcome Survey
(adapted from the Kansas LEAN Survey)

Date: _____

To: (Leadership and Board of Directors)

From: The Evaluation Team

Re: Results of the Outcome Survey for (the initiative).

Enclosed please find the results of the completed Outcome Survey for (the initiative). The purpose of the survey was to assess the importance of community changes resulting from (the initiative's) efforts. Surveys were distributed to 96 initiative or Task Force members and 5 experts in the areas of CVD or initiative development. The overall response rate was very high (47%). Nearly one-half (49%) of Initiative and Task Force Members returned their surveys. The attached report includes the average ratings and the range of responses for each question listed in order of occurrence on the survey. Respondents' written comments are listed verbatim.

In general, respondents rated the outcomes facilitated by (the initiative) as important in accomplishing the mission of preventing CVD. The highest mean importance rating was 4.4 (School Intervention Projects in Salina and Dighton). The lowest mean importance rating was 3.4 (Home Economics Sandwich contest). Taken together, the contribution of the reported community changes to the mission was rated between important and very important (mean = 4.4).

Many of the written comments affirmed the high importance ratings. Comments were provided on the methods used to educate others (e.g., "Excellent approaches to educating educators as well as individuals regarding reduction of fat") and competence of staff members (e.g., "Staff has done a tremendous job").

Respondents indicated that community changes produced by (the initiative) are important to the mission of preventing CVD. The listing of the many accomplishment of (the initiative) and the ratings of their importance are cause for celebration! You should be proud of these accomplishments. If you have any questions, please feel free to call us.

cc: Program Officer, Funding Source

Process Measure	Intermediate Outcome Measure	Distal Outcome Measure
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Using Behavioral Data and Surveys

It is important to document the partnership's impact on *distal outcomes* such as reported behaviors associated with risks for CVD. Behavioral surveys are a strategy for measuring reported changes in the behaviors of individuals. Behavioral surveys help answer the following key evaluation question: “*Is there a change in behavior related to risks for CVD?*”

Behavioral surveys: What and why?

What are they?

- A way to find out about everyday behaviors or habits that increase local citizen's risks for developing CVD.

Why obtain this information?

- Everyday behaviors are associated with more than 50% of all CVD deaths—it is important to identify what behaviors local citizens need to change.
- To provide data for program evaluation.
- To help identify the level of risks for CVD in a community or state.

Why be careful?

- Behavioral surveys are costly.
- They may be insensitive to change.
- They focus on the individual and not on the environment.

This chapter describes behavioral surveys and how to obtain and use data from them. Everyday behaviors or habits that are associated with health problems are called behavioral risk factors. Behavioral surveys include questions about behaviors that put people at risk for CVD and other diseases. These CVD risk factors include inadequate physical activity, poor diet, and smoking. It is estimated that these activities are responsible for more than half of the cardiovascular diseases in the United States.¹

Conducting a behavioral survey of risk factors for CVD provides valuable information about the health status of a community or State. A community can use these data to determine what behaviors need to change and to identify certain groups who are at particular risk for CVD. Furthermore, behavioral data can provide important information for deciding what the project should work on first, planning and implementing community efforts, and tracking changes in local citizens.

Behavioral data strengthen the evaluation of community partnerships. Most of the initiative's effort is directed toward creating local programs and changing policies. These community changes should, in turn, help change citizens' health behaviors. Behavioral surveys provide information on how citizens' behaviors change in response to the efforts of the partnership.

The success of a change in program, policy, or other aspect of the environment thought to reduce risks for CVD is validated by associated changes in behavior. Surveillance of behavioral risk factors provides a basis for both developing and evaluating programs to prevent CVD.

Cautions in Using Behavioral Surveys

Although behavioral surveys can be excellent tools for planning and for monitoring program effects, several issues and limitations should be considered. First, because many behaviors are “caused” by a variety of factors, changes in a particular behavior may or may not be due to the efforts of the partnership. Second, it might also be necessary to sample a large number of people in order to know if the initiative is having an effect. Many of the people in that sample may not have been exposed to the intervention, may not be at risk in the first place (e.g., nonsmokers or those already physically active), or may have changed their CVD risk behaviors for other reasons.

Third, monitoring change in behavior and attributing that change to your efforts is much more difficult than using the data to guide program development. Fourth, even with rather large samples, it may also be inappropriate or difficult

to look for change in behaviors for particular groups such as minorities or specific age groups. Fifth, it may be inappropriate to generalize findings from one community or region to another. Finally, behavior surveys also tend to “blame the victim.” They may focus explanations of the cause of behavior on the individual rather than the environmental conditions that influence behavior. In short, behavioral surveys can be costly, complex, insensitive, or even inappropriate.

Several strategies help reduce these problems with behavioral surveys. First, consider purposely sampling only those exposed to the initiative. Second, include questions on availability and opportunity for behaviors. (For example, have you noticed any change in the availability of low fat foods in the cafeteria? How often are you in a location where you could take a walk or go jogging? If you play tennis, how often do you have to wait for a court?) Finally, use other indicators of program success to complement the behavioral survey.

Using Behavioral Surveys

CDC has developed the Behavioral Risk Factor Surveillance System (BRFSS) for adults. It is now used by all States to help track the prevalence of behavioral risk factors in the United States. This surveillance system uses a standardized protocol to interview randomly selected adults.

The BRFSS is made up of a core set of questions and has several optional modules related to CVD. Questions are available on behaviors to control or monitor hypertension, cholesterol, and diabetes; amount of leisure time physical activity; typical diet; efforts to modify one's diet; and weight control practices. The box below lists sample questions from the BRFSS.

**Sample questions from the
1995 Behavioral Risk Factor Questionnaire**

- On the average, about how many cigarettes a day do you now smoke?
- Have you smoked at least 100 cigarettes in your entire life?
- Are you eating either fewer calories or less fat to lose weight or to keep from gaining weight?
- Not counting carrots, potatoes, or salad, how many servings of vegetables do you usually eat?
- During the past month, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?
- How many times per week or per month did you take part in this activity during the past month?
- In the past 12 months, has a doctor, nurse, or other health professional given you advice about your weight (to lose, gain, or maintain)?
- Have you ever been told by a doctor or other health professional that your blood cholesterol is high?
- Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?
- Have you ever been told by a doctor that you have diabetes?

The CDC has also developed a Youth Risk Behavior Survey (YRBS) to assess risk behaviors among youth. The YRBS is typically conducted in schools but also has modules for “out of school youth.” CVD risk behaviors, such as smoking, begin in youth and continue into adulthood. Community efforts of primary prevention of CVD might use both the BRFSS and YRBS to monitor healthy habits or behaviors among adults and youth.

Adjusting the System to Meet Your Needs

When deciding what, if any, behavioral measures to collect, consider:

- What members and leaders of the community partnership want to know.
- Requirements from grantmakers and others about what questions should be addressed.
- Resources available to conduct the survey.
- What data are already available.

For community partnerships with HIGH resources and requirements for evaluation, consider collecting all of these possible behavioral measures and others of interest. Although resource needs could vary with the sample size and population, conducting behavioral surveys is fairly expensive. The State BRFSS group or a university survey team can provide an estimate of budget and time requirements.

For community partnerships with LOW resources and requirements, consider not collecting any behavioral data or doing so with a small sample of people. This might presume little or no evaluation budget and virtually no reporting requirements. Staff might review data available from other sources. This presumes staff are available for several hours a week or less, with minimal training in evaluation.

Recommended Strategies for Collecting Behavioral Measures on a Shoestring Budget

- Use a smaller sample of survey participants, accepting lower confidence levels for the resulting behavioral data.
 - Collect behavioral survey data less often, perhaps only twice (once at the beginning and again at the end of the project) after several years of intervention activities.
 - Piggyback behavioral questions related to CVD on other existing surveys; for example, school surveys (e.g., the YRBS) or statewide behavioral risk surveys (BRFSS) sponsored by the State health department.
 - Collaborate with local colleges or universities to conduct surveys as part of a class project.
 - Instead of conducting behavioral surveys, rely on archival measures of the products of behavior (e.g., tobacco consumption from excise tax data) or measure changes in the conditions known to prompt or inhibit the behaviors such as access to tobacco products or smoking ordinances.
-
-

Background Information and Materials for Using the BRFSS

This section provides background information on the BRFSS, including a list of optional modules and addresses of people to contact. A copy of relevant portions of the BRFSS questionnaire is provided in Appendix C. Each State has a BRFSS coordinator, and statewide data are available on an annual basis. Call the local coordinator and let them know your State or community is interested in conducting a behavioral survey.

Behavioral surveys: How to obtain and use the data

- Obtain existing behavioral data from local agencies (if necessary, select and conduct behavioral surveys in collaboration with local and State agencies or universities).
- Plot the data and provide feedback on CVD risks factors, such as smoking, fat intake, or exercise levels.
- Use risk factor data to increase awareness and to plan for programs and public concern for CVD, and evaluate the effects of programs.
- It is also recommended to use a graphics program to graph the data.

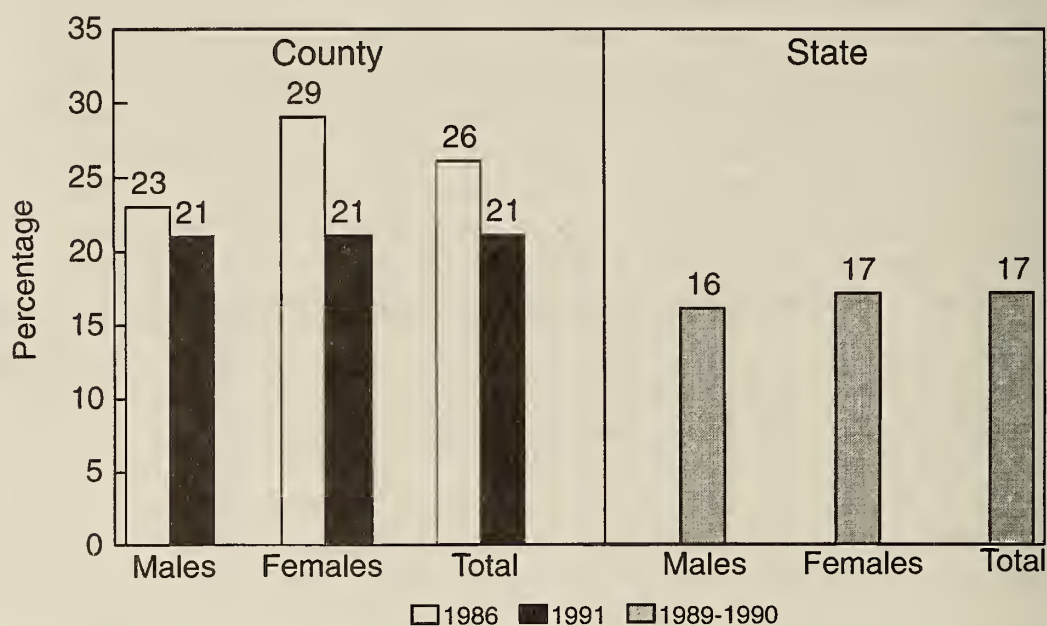
Behavioral surveys should be culturally appropriate and should collect appropriate data for program evaluation. For instance, local programs modified the BRFSS questionnaire and conducted face-to-face interviews for some Native American reservations and rural Hispanic communities where telephones were not commonly available. Other programs have revised the questions or made adjustments to fit cultural patterns and norms such as matching the gender of interviewers to the person being interviewed for one Native American tribe, training community members as interviewers, and eliminating or revising sensitive questions. Questions have been translated into other languages, including Spanish and Chinese, and surveys have been revised to collect information on behaviors not usually monitored by the statewide BRFSS.

The BRFSS questions are considered a valid measure of the State's level of risks for CVD and other health problems. Because it is costly, consider the cautions noted above when determining whether to obtain behavioral data.

Using Data from Behavioral Surveys

Four figures are provided to help illustrate how the data collected from a behavioral survey may be used and shared. Figure 7.1 illustrates the prevalence of hypertension in an average U.S. county for 1986 and 1991 and the State prevalence for 1989–1990. At the county level, the percentage of hypertension for males decreased slightly from 1986 to 1991. For females, the percentage of hypertension decreased markedly from 1986 to 1991. The total population for the county also showed a decrease in the prevalence of hypertension. Data from the State show that the levels of hypertension for males and females are lower than the county level. These data could be shared with local officials to increase awareness about the problem and to secure community involvement.

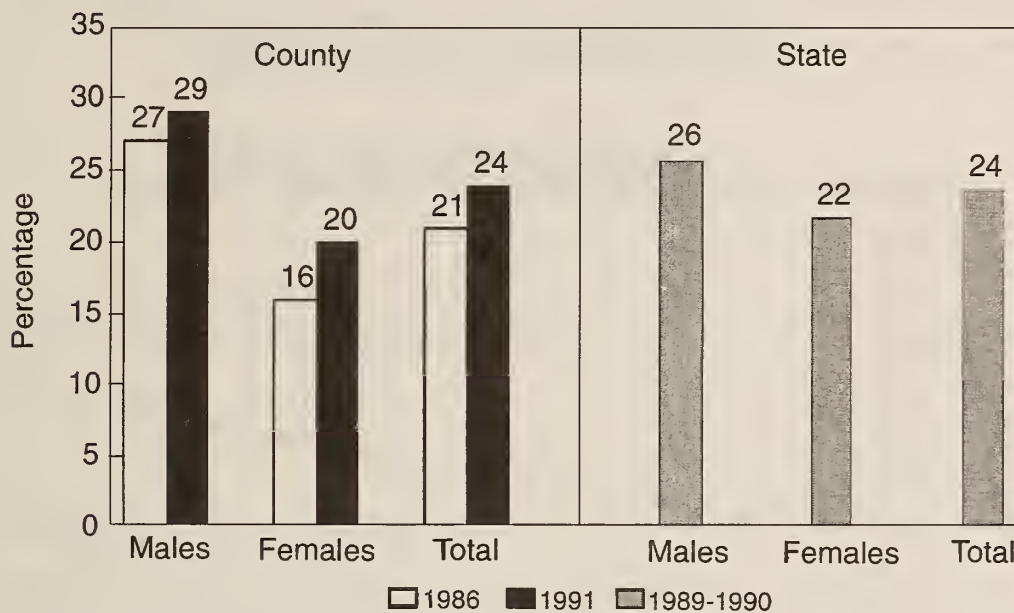
Figure 7.1
Prevalence of hypertension in one U.S. county, 1986 vs. 1991



Source: BRFSS.

Figure 7.2 shows the percentage of survey respondents who reported cigarette smoking in one U.S. county and the State. At the county level, the percentage of cigarette smoking for males, females, and the total population increased slightly from 1986 to 1991. Reported smoking at the county and State levels were comparable. These data can be used to establish the level of the problem at the State and local level.

Figure 7.2
Prevalence of cigarette smoking in one U.S. county, 1986 vs. 1991

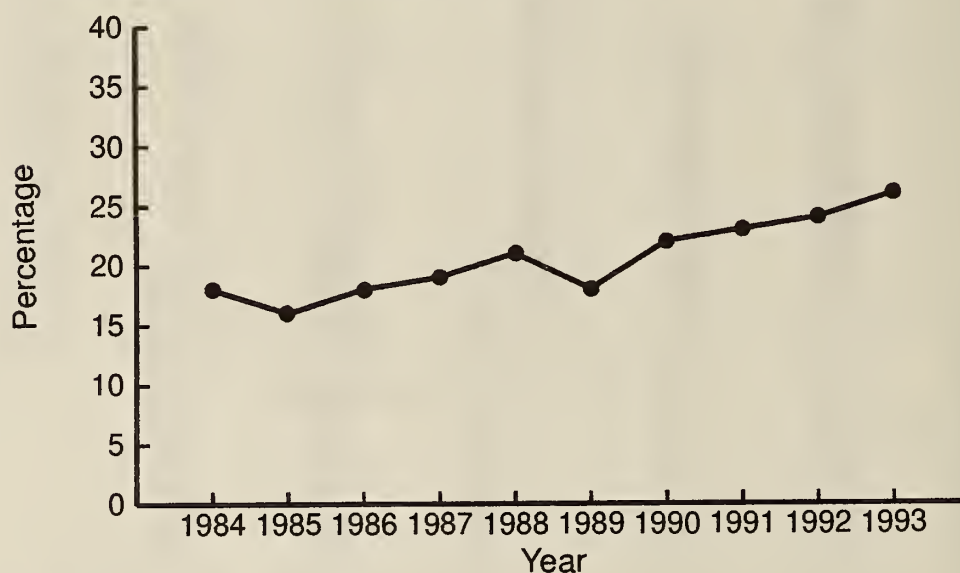


Source: BRFSS.

Figure 7.3 shows the prevalence of adults in California who reported being overweight from 1984 to 1993. The data have been age adjusted using the 1990 California census population. The data show a gradual increase in the prevalence of overweight adults since 1984. They could be used to suggest the need for creating new programs, practices, or policies to reduce overweight among adults.

Figure 7.4 shows the percentage of adults with no leisure time for exercise. Forty-one percent of Black females, 36% of Hispanic females, and 29% of Hispanic males reported not exercising during leisure time. These data can be used to suggest that special exercise programs or messages may need to be developed for particular groups such as Black females, Hispanic females, and Hispanic males.

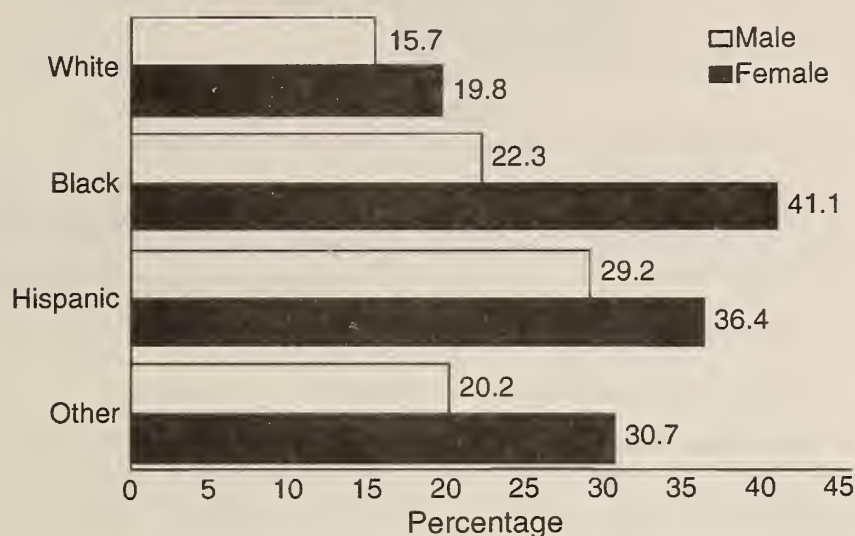
Figure 7.3
Prevalence of overweight adults in California, 1984–1993



Age adjusted to the 1990 California census population.

Source: California BRFSS, California Department of Health Services, Cancer Surveillance Section.

Figure 7.4
Prevalence of adults with no leisure-time physical activity,
by race and gender, 1993



Age adjusted to the 1990 California census population.

Source: California BRFSS, California Department of Health Services, Cancer Surveillance Section.

Learning More About the BRFSS

To learn more about the BRFSS questionnaire and how to obtain data, first contact the BRFSS coordinator in the State health department. A copy of the BRFSS and the modules can be obtained from the CDC through the Office of Surveillance and Analysis, Behavioral Risk Factor Surveillance Branch, 4770 Buford Highway, Mailstop K-30, Atlanta, Georgia 30341-3724. CDC analyzes the data that are collected from administering the statewide BRFSS.

Core questions of the BRFSS, and optional modules are listed in Table 7.1. Those of particular relevance to community partnerships to prevent CVD are noted with an asterisk and are included in Appendix C.

Table 7.1
BRFSS core sections and optional modules

Core Sections		Optional Modules	
Section 1:	Health Status	Module 1:	Smokeless Tobacco Use
Section 2:	Health Care Access	Module 2:	Fruits and Vegetables*
Section 3:	Hypertension Awareness*	Module 3:	Diabetes
Section 4:	Cholesterol Awareness*	Module 4:	Exercise*
Section 5:	Diabetes	Module 5:	Weight Control*
Section 6:	Injury Control	Module 6:	Years of Healthy Life
Section 7:	Tobacco Use*	Module 7:	Quality of Life
Section 8:	Alcohol Consumption	Module 8:	Health Care Utilization
Section 9:	Demographics	Module 9:	Oral Health
Section 10:	Women's Health	Module 10:	Firearms
Section 11:	Immunization		
Section 12:	Colorectal Cancer		
Section 13:	AIDS Knowledge and Testing		

Bibliography

1. Smith, C. A., and Pratt, M. (1993). Cardiovascular disease. In R. C. Brownson, P. L. Remington, and J. R. Davis (Eds.), *Chronic disease epidemiology and control* (pp. 83–107). Washington, DC: American Public Health Association.

Process Measure	Intermediate Outcome Measure	Distal Outcome Measure
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Community-level Indicators of Cardiovascular Health

Community-level indicators of CVD provide a measure of whether the community partnership successfully improved cardiovascular health in the community. In the framework for health promotion presented in Chapter 3, reduced risks for CVD may be estimated by monitoring distal outcomes. This is because a project must plan and implement efforts for several years and create lots of community changes before it can have an effect on the community-wide level of CVD or its risk factors. Two core evaluation questions are addressed using community-level indicators: “*Does the initiative have a community-level outcome related to risks for CVD?*” and “*Is community-level outcome related to changes facilitated by the initiative?*”

Community indicators: What and why?

What are they?

- They are a way to obtain information about the more distal effects of the CVD prevention effort.
- They provide an indicator of cardiovascular health of the community, similar to the way “economic indicators” (such as Median Family Income) measure the fiscal health of the United States.
- Some indicators measure a community’s “health potential” by counting opportunities in the community for low-fat eating, physical activity, and smoke-free living (e.g., number of physical activity facilities per capita).
- Other indicators measure community levels of major risk factors for CVD (e.g., smoking, obesity, and sedentariness).

Community indicators: What and why? (Continued)

Why do it?

- To see if a CVD initiative is improving the cardiovascular health of the community.
- To see if special projects of a CVD prevention effort are reducing risks for CVD.
- To get a better picture of the initiative's effects on your community as a whole.

The incidence and prevalence of CVD may appear to be the ideal measure for program effects—after all, the ultimate outcome of the initiative is to reduce CVD. But, it may take decades for changes in CVD risk factors to result in changes in rates of CVD. Projects simply cannot wait that long to see if they are effective. Cardiovascular health indicators are a quicker way to examine whether the partnership has made the community a more health-promoting place. Indicators do so by measuring risk factors for CVD as well as community-based opportunities for developing lifelong, heart-healthy habits. Table 8.1 provides examples of indicators that measure the cardiovascular health of communities.

Table 8.1
Examples of community-level outcome indicators

Tobacco Control	Physical Activity	Diet
Per capita consumption of cigarettes	Number of physical activity facilities (fields, gyms, pools, etc.) per capita in schools	Presence or absence of low-fat food alternatives in vending machines in public buildings
Percentage of worksites with clean indoor air policies	Miles of walking trails per capita	Proportion of school menu items that meet nutritional guidelines ¹
Prevalence of tobacco use ²	Prevalence of physical activity ²	Prevalence of overweight ²

¹See nutrition objective 2.17 in U.S. Department of Health and Human Services. (1990). *Healthy people 2000: National health promotion and disease prevention objectives*. (DHHS Publication No. PHS 91-50213). Washington, DC: U.S. Government Printing Office.

²Note: These indicators can be used as community-level outcomes although they reflect individual data aggregated for a community.

Measuring the health potential of a community represents a shift in focus for community health promotion efforts, and it represents the belief that a health-promoting community will foster healthier citizens. Community-level indicators of CVD attempt to measure just how health-promoting a community is. Candidate community-level indicators of cardiovascular health have been identified by experts in CVD prevention and evaluation. Lists of these candidate indicators, categorized by the main CVD risk factors of tobacco, physical inactivity, and diet, are presented in Tables 8.4, 8.5, and 8.6 at the end of this chapter. These indicators are being reviewed for quality (accuracy and sensitivity) and feasibility (availability and cost). The accuracy and feasibility of these indicators need to be validated in communities. In the meantime, CVD projects might collect a few indicators that best correspond to their project's efforts. Many of the indicators found in Tables 8.4, 8.5, and 8.6 are also community changes (see Chapter 4). Figure 10.4 in Chapter 10 illustrates how data from community-level indicators can be graphed and displayed.

Community-level indicators: How to's

- Select which indicators the initiative will collect.
- Collect the indicators.
- Summarize and graph the data.
- Present, at least annually, the graphs of community-level indicators to community leaders, project funders, and other interested individuals or groups.
- Present the data as needed to keep prevention of CVD on the local public agenda.

It may be difficult to determine the best indicators for evaluating project efforts—it may be useful to form a temporary task force for selecting indicators. Members of the task force and project staff can oversee selecting, collecting, and disseminating data on community-level indicators. The task force should select indicators and collect data on their chosen indicators within the first year of project initiation. For more information on community-level indicators of CVD, see the section on background information and materials at the end of this chapter.

Adjusting the System to Meet Your Needs

For projects with HIGH resources and requirements for evaluation, consider collecting several cardiovascular health indicators. To do so, the program must commit staff time in order to identify sources of information. The project should have access to someone with basic skills in evaluation. In addition to these personnel costs, selecting, collecting, and graphing data will require a modest budget for supplies.

For community programs with LOW resources and requirements, consider not collecting any cardiovascular indicators or only a few. If less data are collected, programs may choose to present data in a table format rather than needing to graph data. Recommended strategies for collecting cardiovascular health indicators on a shoestring budget are listed below.

Recommended Strategies for Collecting Cardiovascular Health Indicators on a Shoestring Budget

- See if any project partners have already collected these data or if any other group has an interest in doing so (e.g., State or county health departments, State or county Parks and Recreation departments, businesses in the private sector, or universities).
 - Collect data on only a few indicators.
 - Collect data less often, perhaps only twice (once at the beginning and again at the end of the project).
-
-

Background Information and Materials for Community-level Indicators

The previous section described community-level indicators of cardiovascular health and their importance in examining the effects of community-based initiatives for prevention of CVD. This section is written for individuals who are responsible for selecting indicators for programs. Subsections include background information on criteria to use in selecting indicators; the selection process; and tips on how to collect, graph, and present the data. The chapter concludes with a menu of potential community-level indicators (see Tables 8.4, 8.5, and 8.6).

Selecting Community-level Indicators

A health-promoting community creates healthier citizens. Community-level indicators of CVD attempt to measure the degree to which a community is promoting health. All measurement systems have to meet certain criteria in order to be deemed appropriate measures of reality. For example, a scale has to meet certain standards of accuracy, sensitivity, and reliability to be considered a good measure of an object's weight. Because each community is distinct and each CVD prevention effort is different, CVD initiatives must take an active role in determining which indicators are the best measures of their programs' efforts. Those responsible for selecting measures should use several criteria for determining which indicators to collect.

Community-level indicators must be of sufficient quality, feasible to collect, and reliable and valid to be considered a good measure of program effects. Each attribute is considered below.

Quality. The quality of data for an indicator is determined by its accuracy and sensitivity.

Accuracy. This criterion encourages those responsible for the evaluation to examine how carefully and consistently data are collected, recorded, and stored. Sometimes there are so many flaws that the data are inaccurate.

Sensitivity. Those responsible for the evaluation must also consider whether each indicator measures the effects of the initiative. An indicator should correspond to the types of changes the program hopes to make in the community. Also, the measure should be sensitive enough to register when changes occur. For example, if a weight reduction program creates changes in one town, county-wide data on levels of overweight may not register reductions in overweight that are due to program efforts. The county may contain many more times the population of the intervention town, so reductions in the levels of overweight in the town will not be detectable.

Feasibility. The feasibility of an indicator is determined by whether the data are already available, or previously collected for the intervention site, and the costs (in both effort and money) of collecting or analyzing the data.

Availability. This criterion often weeds out a lot of potential indicators. Either data are available or they are not. If the data from the intervention community are not available, those responsible for the evaluation will have to decide if the project is able to collect the data or collaborate with a group to do so. For example, it is likely that the number of hours that physical activity facilities are open (Table 8.5) is not currently collected in a community. If, however, a main goal of a project is to increase physical activity by increasing access to facilities, the project may consider collecting this information itself.

Cost. Those responsible for evaluation must examine how much time, effort, and money will go into collecting or analyzing indicator data. In some cases, data are already being collected on community-level indicators. For example, it is likely that someone collects data on highway funds for non-vehicle transportation (Table 8.5). The challenge is to find who does collect it. Precollected data, or archival data, may be available from health departments, parks and recreation departments, transportation departments, city councils, county commissions, school districts, or voluntary organizations (see Table 8.2).

Reliability and Validity. Reliability and validity are scientific standards used to judge the quality of data. Some aspects of accuracy and sensitivity are included in the definitions of reliability and validity. A reliable assessment produces the same estimates over and over again. For example, no matter how often a scale is used to measure weight, it usually comes up with approximately the same weight for the same object. Some assessments of measurement reliability are complicated. For example, police citations for selling tobacco products to minors may be a good marker of the level of sales to minors. However, if more police are hired, an increase in citations may not be due to increased sales but to increased ability to enforce the law: the measurement system changed.

Measurement validity is the extent to which an instrument measures what it is intended to measure. For example, a ruler is a valid measure of length. A ruler is not a valid measure of weight. This example is obvious, but some other assessments of measurement validity are not so obvious. For example, is supermarket shelf-space dedicated to low-fat milk a valid measure of low-fat milk consumption? Is it a valid measure for a community's diet. Arguments can be made for and against the validity of this measure.

Some recommended community-level indicators are of known reliability and validity. For example, the prevalence of tobacco use as measured by some behavioral surveys is both valid and reliable. Many community-level indicators we provide here are new and are being pilot-tested. For example, the percentage of health care providers that routinely advise patients to exercise is a relatively untested indicator. Such indicators of the cardiovascular health of a community are of undetermined reliability and validity.

Most community-level indicators will be collected in different ways in each community. The reliability and validity of these measures will remain undetermined, because the time and money required to validate them would preclude their use. Such measures may still provide very useful indicators of the effects a program is having on the community.

What is the message? Each program may wish to collect data on a variety of community-level indicators. Programs could collect data on some indicators of known reliability and validity in order to compare data from their community to State or national norms. Programs will also benefit from collecting data on some indicators of unknown reliability if these indicators may be particularly sensitive to program efforts.

The Selection Process

As recommended earlier in the chapter, the initiative may wish to form a task force to guide the process of selecting indicators. The selection process includes (a) selecting an initial long list of candidate indicators, (b) evaluating each candidate indicator's quality and feasibility, and (c) creating a short list of candidate indicators.

Creating a Long List of Candidate Indicators. When choosing what, if any, community-level indicators to collect, consider (a) what members and leaders of the community partnership want to know, (b) requirements from grantmakers and others about what evaluation questions should be addressed, and (c) resources available to address these questions.

With these considerations in mind, the task force first selects a long list of indicators from Tables 8.4, 8.5, and 8.6; also, the task force may choose to develop or add other indications that are not listed. Members of the initiative, leadership, and grantmakers should help guide the selection process.

Factors to consider when choosing CVD community-level indicators

Which sectors are involved in the community effort?

- Schools.
- Worksites.
- Public and private agencies.
- Religious institutions.
- Community at large.

**Factors to consider when choosing
CVD community-level indicators (Continued)**

Which strategies are being used to promote changes in the community?

- Providing information and skill building.
- Barrier modification and environmental change.
- Policy and regulation.

On which behavioral risk factors does the program focus?

- Tobacco control and reduction in use.
- Increased physical activity.
- Improved diet and nutrition.

The task force should include a variety of indicators on its long list. They should include indicators from sectors of the community that are creating changes to promote cardiovascular health. For example, if businesses are active in program efforts, the project may collect worksite-based indicators such as the percentage of worksites that allow staff to participate in physical activity during work hours (Table 8.5). It is also important to include indicators that measure strategies used by the program. For example, a program that puts most of its efforts into policy change should select indicators that measure policy changes, such as the number of existing tobacco control ordinances (Table 8.4). Finally, a program focusing on only one of the major risk factors for CVD should select indicators within that domain. For example, a program that seeks to reduce CVD by increasing physical activity may limit itself to indicators related to physical activity (Table 8.5).

Evaluating Candidate Indicators. After a long list of candidate indicators is identified, those responsible for evaluation review each candidate indicator. The task force may wish to create worksheets on which members can note the strengths and weaknesses of each candidate indicator. The task force may assign several indicators to each member. These members can make the phone calls necessary for collecting information about quality and feasibility of the indicators and report the results back to the group. In addition to collecting information on quality and feasibility, the worksheets can provide space for data issues (who will secure the data, how it might be collected, or who could use the data) and tailoring (depending on the program and evaluation goals, the indicator may need to be revised or require further definition). The task force should spend some time brainstorming on who would be good contacts for information about indicators. Figure 8.1 gives an example of a worksheet on evaluating a candidate indicator.

Figure 8.1
Example worksheet for a candidate indicator

Candidate Indicator #6: “Proportion of shelf space for lower-fat milk (2%, 1%, and skim) to whole milk in grocery stores”	
Task force member: Jane Doe Name, affiliation, phone number of contacts: John Smith, Brand X Supermarket, 000-0000. Sally Jones, State Dairy Council, (000) 000-0000.	
I. Quality	The data may be sensitive to and accurately reflect changes in barriers to healthy nutrition; could reflect increased local demand for lower-fat products because of program efforts; may be worth trying.
II. Feasibility	Can't find anyone who presently collects these data. Getting data for this indicator is likely to require in-store observations. This would be time-consuming. However, an initial study of 15 stores in 8 communities had the same power as a telephone survey of 1,600 individuals, at a fraction of the cost. Could explore getting high school home economics classes to measure this for class credit.
III. Data issues	It would be appropriate for either community-based programs and State health departments to use these data, although collection would likely occur at the community level.
IV. Tailoring	Decisions would have to be made concerning how many stores make up a representative sample.

Creating a Short List of Candidate Indicators. With information for each candidate indicator such as that provided above, the task force can create a short list of indicators. None of the indicators will be perfect—the task here is to find the best indicators possible. The quality and feasibility of each candidate indicator should be reviewed and compared with other indicators. The quality criterion consists of accuracy and sensitivity. Sometimes there are so many flaws that the data are inaccurate. Seriously flawed indicators should be excluded from the list of candidate indicators. Indicators that are not sensitive—those that do not correspond to program efforts, or that will not register program effects—should be excluded from the initial list of candidate indicators.

The criterion of feasibility consists of availability and cost. Many indicators will not be in existing databases. If they are potentially important measures, the project may choose to collect them, or encourage another group, such as a local university or volunteer organization, to collect the data. If an indicator does not correspond to project efforts and is not readily available, it should be excluded

from the list. Some indicators may require on-site observation, such as usage of bike or fitness trails, or locally created surveys. Indicators that require more resources than are feasible should be excluded from the initial list of candidate indicators.

Those responsible for evaluation will end up with a short list of candidate indicators. The evaluators may collect data on each one.

Collecting, Graphing, and Communicating Data

Tips on Collecting Data

Those responsible for evaluation will have to determine who will collect indicator data, how often it will be collected, and how the data will be stored. If the program has HIGH resources and requirements for evaluation, hired outside evaluators will be the natural choice. If the program has LOW resources but still wishes to collect indicator data, one or several members of the program may volunteer to collect the data. Members may also develop innovative collaborations with groups (such as 4-H clubs, extension agents, community service groups, or health organizations) who may do the on-site data collection.

Table 8.2 provides examples of sources for archival data on community-level indicators of cardiovascular health.

Table 8.2
Obtaining CVD community-level indicators: Some resources

CVD Risk Factor	Potential Resources
Tobacco Control	<i>Organizations:</i> Local and State health departments, local and State education departments, local school districts, local and State departments of revenue and tax commissions, American Cancer Society, American Heart Association, CDC
Physical Activity	<i>Organizations:</i> Local and State health departments, local and State parks and recreation departments, local and State education departments, local and State transportation departments, local school districts, American College of Sports Medicine, CDC
Diet	<i>Organizations:</i> Local and State health departments, local and State education departments, local school districts, American Cancer Society, American Heart Association, CDC

Those responsible for evaluation should determine how often the data will be collected. The data may be collected monthly, quarterly, annually, or at less regular intervals. Once collected, the data may be stored in file folders or in computer databases.

Table 8.3 provides a sample data collection form. It illustrates how data might be stored for the number of smoking cessation programs available in the community by sector (3 years of baseline established by interviews with health care providers).

Table 8.3
Data Form

SECTOR	Year					
	1992	1993	1994	1995	1996	1997
Worksites	1	2	3			
Schools	0	0	1			
Health Organizations	2	2	2			
Others	1	2	3			
Total	4	6	9			

Whenever possible, the initiative should collect historical baseline data for 3–5 years before program onset. Baseline data are measures of what was happening to CVD risks in the community before the community partnership existed. Three to five years of baseline data will tell you whether the indicator for CVD was increasing or decreasing when the program began its efforts. Knowledge of these trends will help the initiative determine what impact its efforts might have on CVD in the community.

Tips on Graphing Data

You will have to determine who will graph indicator data and how often graphs will be updated. If the program has HIGH resources and requirements for evaluation, hired evaluators will be the natural choice. If the program has LOW resources but still wishes to collect and graph indicator data, one or several members of the program may volunteer to graph the data. Members may also develop innovative collaborations with groups (such as business clubs, university research groups, individuals with an interest in CVD reduction, or health organizations) who may graph data for the initiative.

Tips on Presenting Data

Data often speak louder than words. Newspapers often print local data about issues of national importance. Local civic organizations often seek speakers who can present data on the well-being of the community. For example, if a project member had a graph of the prevalence of smoking cessation programs in the community and an idea of how many people smoke in the community (usually over 25%), the project member would be able to make a strong case that the initiative was making changes to increase the health of the community. For other tips on communicating data, see Chapter 11.

Community-level Indicators — A Menu of Options

Tables 8.4, 8.5 and 8.6 list examples of potential community-level indicators of cardiovascular health. Each table represents one of the major risk factors (tobacco use, physical inactivity, and diet) with indicators classified by three broad intervention strategies (information and skill building, barrier modification and environmental change, and policy and regulation). These lists are comprehensive but not exhaustive—initiatives may identify others that best measure their efforts. Each indicator will have to be tailored to meet the needs of a State or local initiative. For example, “Clean indoor air policies” (Table 8.4) does not specify exactly what data to collect. Evaluators may decide that “the percentage of all public buildings with clean indoor air policies” is the best indicator of the efforts of the CVD prevention initiative.

Table 8.4
Potential CVD community-level indicators
for tobacco control

Information and Skill Building

- Surveillance data on tobacco sales to minors
 - Existence of smoking control programs in public health agencies
 - Existence of smoking cessation campaigns within worksites
 - Number of community coalitions for tobacco control
 - Level of involvement of community coalitions in tobacco control
 - Training of local leaders on tobacco advocacy
 - Presence or absence of advertising of tobacco paraphernalia (clothing, pictures, etc.)
 - Presence/absence of tobacco control advertising, media messages, or hotline
 - Existence of smoking cessation services within (across) settings in the community
 - Prevalence of tobacco use (See Chapter 7)
-

Table 8.4
Potential CVD community-level indicators
for tobacco control (Continued)

Barrier Modification and Environmental Change

- Percentage of restaurant seats within no-smoking sections
- Price of tobacco products
- Percentage of worksites with no-smoking areas
- Presence/absence of tobacco vending machines in restaurants or hotels
- Disappearance of tobacco products (store inventory)
- Observations in smoking and non-smoking areas
- Location of tobacco vending machines in restaurants, hotels, etc. (i.e., are they by the front door where access is easier?)
- Per capita consumption of cigarettes
- Presence/absence of tobacco advertising, promotion, or free distribution of tobacco products in the community, near schools, or worksites

Policy and Regulation

- Clean air laws for public buildings, restaurants, private worksites, daycare, schools, etc.
 - Prohibition on use of tobacco products on public property (e.g., venues, sports stadiums, housing, and worksites)
 - Fines or loss of license for violations
 - Excise tax on tobacco products (local option)
 - Existence of community tobacco control ordinances
 - Excise/license fee for tobacco sales
 - Vending machine regulations in communities
 - Restrictions on advertising for tobacco products on public property, or near youth areas (e.g., schools)
 - Enforcement of Synar ordinances (no sales to minors) throughout the community
 - Restriction on tobacco product ads in communities
 - School policies banning smoking
 - Evidence of enforcement (e.g., fines and litigation) of tobacco ordinances and laws
 - Youth access laws in communities: crime for sale to youth and enforcement of laws
-

Table 8.5
Potential CVD community-level indicators for physical activity

Information and Skill Building

- Percentage of time in physical educational (PE) classes spent on “lifetime” exercises
- Percentage of health care providers that routinely advise patients to exercise more
- Availability of materials in worksites linking sedentariness with CVD
- Prevalence of physical activity (see Chapter 7)
- Number of media reports (TV, radio, print) linking physical inactivity to CVD; also, amount of space or length of time of report

Barrier Modification and Environmental Change

- Observation of usage (in malls or on trails)
- Percentage of walking trails (or miles of walking trails per capita)
- Percentage of bike lanes (or ratio of bike lanes to streets or miles of bike lanes per capita)
- Number of physical activity facilities (fields, gyms, pools, etc.) per capita in schools
- Membership in physical activity organizations (Y's, health clubs, etc.)
- Availability of facilities (fields, gyms, pools, etc.) to community members
- Number of physical activity facilities (fields, gyms, pools, etc.) per capita in worksites
- Hours that physical activity facilities (fields, gyms, pools, etc.) are open
- Number of worksites that sponsor teams, jogging groups, mall walking, sporting events, etc.
- Number of worksite/offices, etc., that allow staff to participate in physical activity during working hours
- Tracking of targeted items (such as sales or rental of sports equipment and videos)
- Capacity of physical activity facilities (fields, gyms, pools, etc.)
- Acres of parks or recreational space (per total community acres or per capita)
- Census of use of physical activity facilities (worksite, community, etc.)
- Number of physical activity events in the community per year
- Presence or absence of formal worksite policies that support physical activity (e.g., flextime or longer breaks/lunches)

Policy and Regulation

- Highway funds for non-vehicle transports (ISTEA): amount of money and number of projects
 - Local/State policy to include physical activity in curriculum of public schools K–12
 - Include green-walk/bike ways in zoning/rezoning requirements
 - Amount or percentage of local budget per capita devoted to physical activity/recreation
 - Insurance reimbursement for physical activity services and counseling in health organizations
 - Presence or absence of policies promoting inclusion of recreation facilities with new construction/remodeling/restoration
 - Local/State policy to include physical activity in curriculum of private schools
 - Evidence that local zoning board considers health (CVD) in its decisions
 - Extent of public schools (K–12) that include lifetime activity skills
-

Table 8.6
Potential CVD community-level indicators for diet

Information and Skill Building

- “Point-of-purchase” information provided (e.g., in cafeterias, vending machines, stores, and restaurants)
- Healthy menus in schools, worksites, and other places
- Training for cooks in cafeterias (schools, worksites, and restaurants)
- Presence or absence of shopping tours/demonstrations/food sampling in supermarkets
- Presence or absence of low-fat cooking via the media (TV) offered on Saturday or Sunday
- Number of contests for diet change within the community
- Presence or absence of food pyramid charts in “learning” environments
- Number of media reports (TV, radio, and print) linking nutrition to CVD; also, amount of space or length of time of report
- Existence of food preparation classes within (across) settings in the community
- Prevalence of overweight individuals (see Chapter 7)

Barrier Modification and Environmental Change

- Presence/absence of healthy food alternatives in vending machines in schools, worksites, and public buildings
- Bar codes sales data on foods that prevent or increase risks for CVD
- Proportion of low-fat items in schools, via menu analysis of use of indicator items such as low-fat milk (also use for worksite, restaurants, etc.)
- Inventory control data (e.g., schools and worksite cafeterias) for food usage
- Proportion of low-fat items in stores (via use of indicator items such as low-fat milk)
- Proportion of shelf space in grocer stores of low-fat foods
- Observations of patrons at grocery stores (e.g., percentage choosing low-fat foods)
- Number of “fast food” restaurants per capita
- Presence/absence of farmer’s markets, coops, green grocers

Policy and Regulation

- Number or percentage of schools with lunch menus consistent with nutritional guidelines
 - Number or percentage of schools with policies requiring alternatives to snack/junk food in vending machines
 - Proportion of publicly funded food programs that follow nutritional guidelines
 - Index of local district policies regarding nutrition at school, day care, after-school, and weekend events
 - Commodity food programs: presence or absence of low-fat foods
 - Presence or absence of State guidelines, monitoring guidelines, and enforcement of nutrition in schools (FDA or other)
 - Presence or absence of food policies for special populations (older adults, Women, Infants, and Children [WIC])
 - Third-party reimbursement for dietary counseling
 - Monitoring or regulating claims made by food retailers regarding the “heart healthiness” of food items they sell
 - Adoption of formal policy that supports healthy eating at worksites
-

Process Measure	Intermediate Outcome Measure	Distal Outcome Measure
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Conducting Interviews with Key Participants

Conducting semistructured interviews with key participants helps understand the *process*, *intermediate outcomes*, and *distal outcomes* of the initiative. This qualitative component is designed to identify critical events in the history of the initiative and their meaning for participants. Interviews help answer the following key evaluation question: “*What critical events seem to spur rates of community change?*”

Interviews with key participants: What and why?

What are they?

- A way of learning about important events in the life of the initiative.

Why do it?

- To find out what events were important and why they were important.
- To help identify factors that affected the initiative’s success.
- To help identify negative side effects.
- To provide a history of the initiative.
- To obtain insights that can be used in planning and renewal efforts.

Interviews with key participants provide qualitative information about important events in the initiative and their meaning. Key participants are people who have been with the coalition since its inception or who have been most actively involved. They are frequently project staff and active members of the coalition such as committee chairpersons. These key participants are interviewed to gain

their insights into important events in the life of the initiative, lessons learned, and future directions.

Hindsight is 20-20 vision; sometimes one must reflect back over the development of a community initiative to identify events that proved to be important. Semistructured interviews gather information about critical events in the unfolding of the initiative from the perspective of those most involved. Important events that are revealed in these interviews can help the initiative during transitions such as changes in staff, the board of directors, and the initiative's mission.

This chapter describes how to conduct these interviews and how interviews can help identify and explore critical events.

Interviews with key participants: How to's

- Staff and leadership generate names of active participants.
- Interviewers are selected to conduct interviews.
- A designated interviewer combines information from the interviews in a report.
- The initiative and funders receive a copy of the report.

Those assuming responsibility for this component of the evaluation ask project staff and others for the names of several persons who have made large contributions in time and effort to the initiative and who have extensive knowledge about the initiative and the community. Evaluators conduct individual phone or face-to-face interviews with four to eight of the most frequently nominated persons. The interviews help identify critical events and explore why they were important. Key participants identify the critical events. Interviewers ask questions about each event. Some key questions are listed below.

Interviews about critical events: Some key questions

What are the critical events in the history of the initiative?

- Why was the event important?
- What was the context for the event?
- What key actions, actors, and other resources were required?
- What barriers and resistance were encountered?
- What were the consequences of the event for the initiative and the community?

What lessons did the initiative or individual learn?

What future directions should be taken by the initiative?

Project evaluators conduct the interviews and combine participant comments in a report. Each interview lasts about 90 minutes. The questions attempt to identify critical events, consequences for the initiative and the broader community, and future directions for the initiative. The interview could be audiotaped, with consent of the interviewee, to aid in preparing the report. In the report, evaluators combine comments from all participants who reported on a particular event. Comments are not linked to individual interview participants, so a degree of anonymity is maintained. The initiative can use the report to provide a history of the initiative, aid in funding efforts, assist in planning for the future, and better understand the initiative.

Key participant interviews could be conducted every several years or in the last year of a grant period. More regular interviews would yield valuable information, such as the current barriers faced by the initiative, that could help the initiative in troubleshooting how to complete current projects.

Adjusting the System to Meet Your Needs

Consider the following when deciding how to gather qualitative information about the partnership

- What members and leaders of the community partnership want to know.
- Requirements from grantmakers and others about what questions should be addressed.
- Resources available to address these questions.

For community partnerships with HIGH resources and requirements for evaluation, consider doing annual (or even more frequent) interviews with six to eight key participants in the partnership. This might presume the availability of active coalition members and staff to talk about the partnership for about 2 hours each, 20 hours or more time of a person with basic skills in interviewing, and secretarial time in preparing a report.

For community partnerships with LOW resources and requirements, consider fewer interviews or a less formal approach to interviewing. Recommended strategies for conducting interviews with key participants in partnerships with limited resources are listed on the following page.

Recommended Strategies for Interviewing on a Shoestring Budget

- Conduct interviews with only three to four key participants in the coalition.
- Summarize the information informally in a few statements about broad categories such as key events and lessons learned.
- Instead of using individual interviews, collect information in informal listening sessions with a group of representative members. Flip charts or bulletin boards can be used to capture member input on:

Key events (and dates):

Why they are important

Key actors

Barriers and resistance

Consequences for the coalition and the community.

Lessons learned.

Future directions for the partnership.

Materials on Conducting Interviews

This section provides a checklist and materials for conducting interviews with key participants. The format for the interview includes a list of questions. This section also includes a sample of a critical events report for a community initiative to reduce the risks for CVD.

Interview Checklist and Format

Table 9.1 provides a checklist for preparing for the interviews, conducting the interviews, and preparing the report. Figures 9.1 and 9.2 provide samples of formats for the critical interview, including a cover sheet with introductory questions and specific questions for each critical event.

Table 9.1
Checklist for conducting interviews

Before the Interview

- Make a copy of the cover sheet on which to list the critical events (see Figure 9.1).
- Review the list of questions for each event (see Figure 9.2).
- Prepare pages, blank or with headings, to record responses from key participants or use a tape recorder to record conversations.
- Look up the dates for some major events (e.g., grant awards or hiring staff) to use as a benchmark when a participant has difficulty remembering the date of a critical event.
- For each participant, call in advance to arrange a convenient time for a 90-minute interview.

During the Interview

- State the purpose of the interview and remind the key participant that the interview is intended to focus on the events critical to the entire life of the initiative.
 - Describe the format for the interview and approximately how long it should take (approximately 1.5 hours).
 - Ask the key participant to identify the critical events, such as when key staff were hired, noting an approximate month and year when the event took place.
 - Discuss each event using the interview questions (see Figure 9.2).
 - After each event is discussed, discuss overall lessons and future directions (see Figure 9.2).
-

Table 9.1
Checklist for conducting interviews (Continued)

During the Interview (cont.)

- Close the interview by thanking the participant for his or her time and offer to send a copy of the completed report.

Preparing the Report

- Review notes from the interviews (or transcribe interviews if a tape recorder was used).
 - Combine lists of critical events from all interviews.
 - Combine responses to questions for common critical events.
 - Summarize responses for each critical event. Use the language of the key participant.
 - Distribute report to project staff and leadership and other interested constituents.
-

Figure 9.1
Cover sheet for the Critical Events Interview

Initiative:

Key Participant:

Participant's Position (e.g., health department official, parent, teacher):

Participant's Involvement with the Initiative (e.g., founding partner, member, chair):

Date of Interview:

Interviewer:

Interview Process: Ask introductory questions: What key events or incidents were critical to the initiative's development? Its major accomplishments or successes? Its setbacks or challenges?

After listening to the key participant and taking notes on this page, identify the several particularly important events (usually 6–12 discrete events). State these to the participant, asking for agreement about them. Each identified critical event will then be considered separately.

Notes:

Date (month, year)

Event

Figure 9.2

Interview questions

For each Critical Event, ask about:

DATE of the event: (month, year)

RATIONALE: (Why was this event particularly important?)

CONTEXT OR CONDITIONS: (What was going on at the time of the event? What made the conditions right for this to happen?)

KEY ACTIONS AND ACTORS: (What key actions brought about the critical event? Who were the key actors?)

KEY RESOURCES: (What key resources [e.g., people, financial resources, political influence] were used to bring about the critical event? How were these resources used to overcome barriers and resistance?)

BARRIERS AND RESISTANCE: (Were the group's actions met with barriers or resistance? What types of barriers? Who resisted?)

CONSEQUENCES for the initiative: (What were the consequences or results of the critical event for the initiative?)

CONSEQUENCES for the community: (What were the consequences for the community?)

After all identified events have been discussed, ask about:

OVERALL LESSONS: (Overall, what lessons have you learned from your involvement with the initiative? What lessons have you learned from the initiative's attempts to define and act on its mission?)

FUTURE DIRECTIONS: (What issues does the initiative face in the future? What challenges should be addressed?)

Sample Report

This chapter concludes with a sample report on critical events. A Critical Events Report includes a list of key participants interviewed, a list of critical events that were identified, and a narrative for each critical event. The narrative describes the responses of the interviewees when asked questions about each critical event. When two or more key participants identified the same event, the responses are combined in the report. Figure 9.3 provides an example narrative for one critical event for Kansas LEAN, a state wide coalition to prevent CVD.

Figure 9.3
Sample Critical Events Report for an initiative to prevent CVD

List of Key Participants Interviewed

- Director, Kansas LEAN.
- Senior Program Officer, Kansas Health Foundation.
- Director, Bureau of Office of Health Promotion and Chronic Disease, Kansas Department of Health and Environment.
- Official, County Extension Office.
- Official, Kansas Wheat Commission.

List of Critical Events in the Life of the Kansas LEAN Initiative

1. Initial formation of Kansas LEAN (fall 1988).
2. Development of Partnerships and Task Forces (spring 1989).
3. Collaboration with Childcare Association (late spring 1989).
4. Kansas Health Foundation awards the Kansas LEAN grant (July 1990).
5. Hiring Kansas LEAN's Director (July 1990).
6. Developing the Child Care Nutrition Curriculum (September 1990–April 1994).
7. Action planning (October 1990–April 1991).
8. The first Annual Kansas LEAN Partners' Meeting (November 1991).
9. Kansas LEAN facilitates the USDA Food Safety education project (winter 1991).
10. Kansas LEAN awarded USDA technical assistance grant to conduct the CDC Dietary Intake Survey (completed summer 1993).

Critical event: 7. Action Planning

DATE of the Event: October 1990–April 1991

RATIONALE: The action plan kept us on a time line. Things were no longer pie in the sky. We put up time lines that gave us something to go against. The action plans are very much a working document.

CONTEXT OR CONDITIONS: The initiative had spent a year talking in generalities. We were ready to get down to action. We were holding press conferences that made a commitment to the public to do something. We took all the change objectives and laid out our action plan by Task Forces. Each Task Force met to further develop the action plan. Most of us were not used to being in a true collaboration. The diversity of the group required that we figure out how people fit. If we didn't define roles, we would lose people.

KEY ACTIONS AND ACTORS: The director and staff were key leaders. They forced us to decide what we were going to do. The monthly brainstorming was very helpful. The survey of importance and feasibility was critical. The survey gave all the Task Force members and partners a chance to get involved.

KEY RESOURCES: The task forces still had control over what would be pursued. The University of Kansas evaluation group and Kansas LEAN staff were very helpful in providing technical support.

BARRIERS AND RESISTANCE: Because people had experienced other types of strategic planning, some eyes rolled when we started. Some thought it would not produce anything useful. Eventually people believed that this planning process would be different.

CONSEQUENCES (for the initiative): The strategic plan made the initiative members feel that we were finally underway. It helped with public perception. We now had substance. This is what we are and what we do. It brought the initiative together on its priorities. For example, the emphasis on early nutrition made it easier for people to see that children were a priority for the initiative. It also made it much easier to talk with potential funders.

CONSEQUENCES (for the community): Strategic planning got programs in place. Without it, we might not have began to work on the child care curriculum. The action plan put programs out there that weren't there before. Action planning also helped us to pull in new partners. As the plan grew, additional partners become obvious. Partners could see how they could be involved with the initiative and its mission.

PART III

Integration and Conclusion

What's Ahead . . .

- ❖ Using the Evaluation System to Answer Key Questions
- ❖ Communicating Information about the Initiative
- ❖ Some Reflections on the Evaluation System

Using the Evaluation System to Answer Key Questions

This chapter shows how information obtained from this comprehensive evaluation system can be interpreted to address significant evaluation questions. In order for an evaluation system to be useful, it must answer key questions of relevant audiences. Listed below are several questions that appear to be of interest to community leadership, grantmakers, and the community at large.

Evaluation questions of possible interest

- Was the community mobilized to reduce risks for CVD? (Chapter 4)
- What changes in the community resulted from the initiative? (Chapter 4)
- Is there a change in behavior related to risks for CVD? (Chapter 7)
- Were members satisfied with the partnership? (Chapter 5)
- Were the community changes important to reducing risks for CVD? (Chapter 6)
- Does the initiative have a community-level outcome related to the risks for CVD? (Chapter 8)
- Is community-level outcome related to changes facilitated by the initiative? (Chapters 4 and 8)
- What critical events seemed to spur rates of community change? (Chapters 4 and 9)

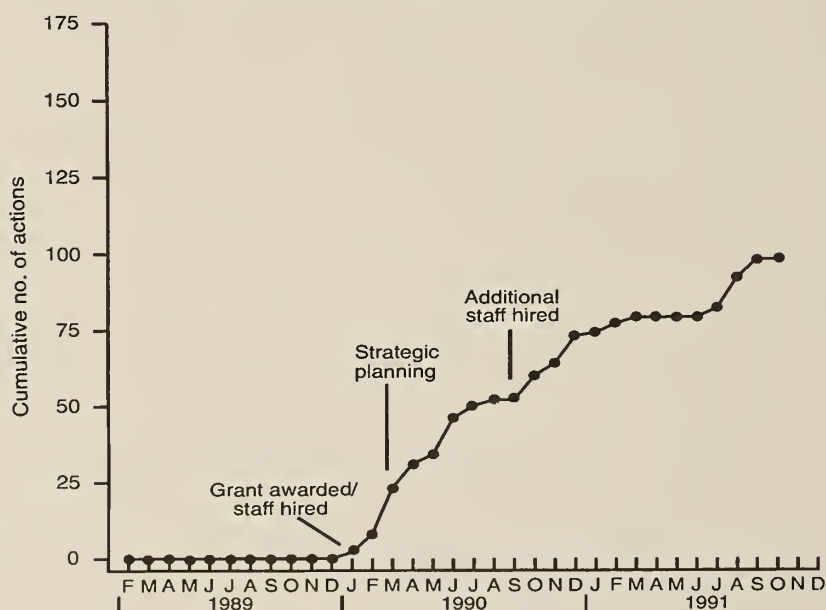
This chapter describes how the measurement system can be used to answer many of these questions of interest.

Was the Community Mobilized to Reduce the Risks for CVD?

The question of community mobilization is important for collaborative partnerships that serve as catalysts for community change. Measures of community action capture community mobilization. Community actions are actions taken by staff, leadership, volunteers, and community members associated with the initiative to facilitate new or modified programs, policies, and practices relevant to the mission (see Chapter 4 and Appendix A).

Figure 10.1 illustrates data on community mobilization. It shows community actions by members and staff of a hypothetical initiative designed to reduce risks for CVD. Each community action is a different event, such as meeting with school food service personnel about reducing the fat content of school lunches. Community actions are graphed cumulatively (i.e., new events are added to the previous events). With this type of data, a flat line suggests no activity; the steeper the slope of the line, the more activity. This type of graph is used because it effectively shows the developmental process of community mobilization.

Figure 10.1
A hypothetical coalition to prevent CVD:
Community actions taken*



*Examples of community actions include events such as meeting with school food service personnel about reducing the fat content of school lunches, holding a community forum to hear citizen's concerns about secondhand smoke, and meeting with staff of the department of transportation to discuss building bike paths.

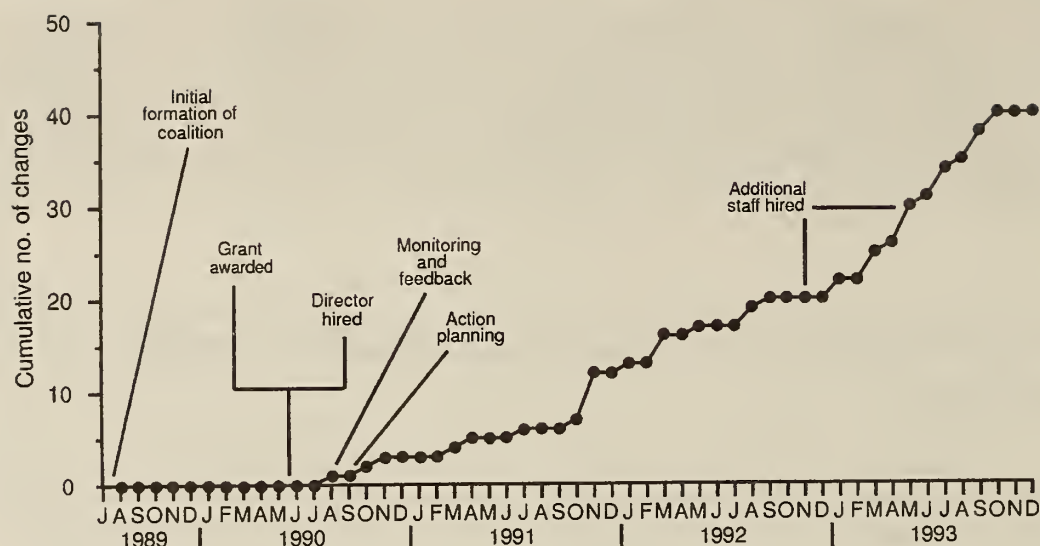
For this hypothetical coalition (Figure 10.1), during the first year, the graph depicts a flat line, showing no activity. An increase in activity is shown after the grant is awarded and staff is hired. Sharp increases in actions are also noted after the completion of planning and the hiring of an additional staff person. Some leveling off of activity is shown in the spring 1991 with another increase in the last few months of data collection. Overall, the data show a steady level of community action that was maintained over a two-year period; thus, the data suggest that the community and staff were mobilized to bring about community change.

What Changes in the Community Resulted from the Initiative?

Community change is defined as new or modified programs, policies, or practices related to the mission (see Chapter 4 and Appendix A). Figure 10.2 shows the pattern of community change for the Statewide initiative Kansas LEAN to reduce the risks for CVD and some cancers. Kansas LEAN has the primary mission of reducing consumption of dietary fat. Illustrative community changes for Kansas LEAN included developing nutrition information for teachers and day care providers (new program) and collaborating with a local supermarket chain to implement shelf prompts and price reductions to increase purchases of lower fat food items (new program).

Figure 10.2 shows steady growth in community change over a three-year period. Community change began in the summer of 1990 after receiving a grant and hiring a director. Implementation of a monitoring and feedback system and action planning also occurred before the increase in community change was shown. The longest and sharpest climb in community change was shown beginning in fall 1992 after hiring of additional staff.

Figure 10.2
Kansas LEAN: Community changes produced

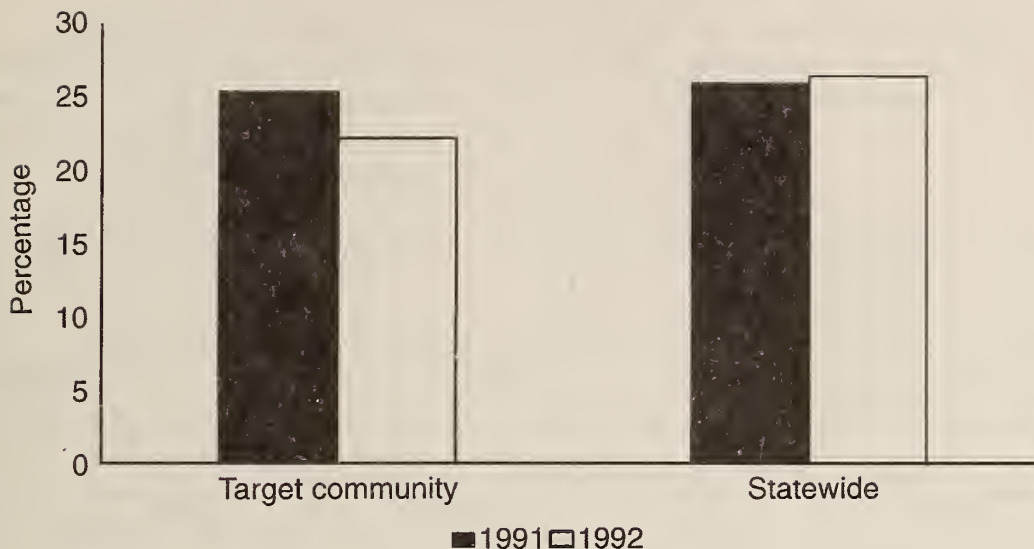


Was There a Change in Behavior Related to Risks for CVD?

Behavioral surveys can be used to collect information to address whether the initiative produces a positive effect on behavior associated with the risks for CVD. The BRFSS, available from the CDC in Atlanta, is one potential source of available behavioral data. The survey includes questions about nutrition, tobacco use, and physical activity (Chapter 7).

Figure 10.3 shows data from the BRFSS on the percentage of people who report daily or weekly use of cigarettes at two points in time (1991, the first year of implementation; 1992, the second year) for a hypothetical CVD prevention project. Data from the target county are compared with statewide data. Reported regular use of cigarettes decreased in the target county with a slight increase statewide. Although other factors may account for the results, these findings suggest that the initiative may have had a modest effect on tobacco use.

Figure 10.3
Reported daily or weekly cigarette use among adults



Source: BRFSS.

Were Members Satisfied with the Partnership?

Support and challenges for the initiative may be suggested by ratings of member satisfaction. We recommend using a Member Satisfaction Survey to gather data on satisfaction with the initiative in a number of areas such as competence of staff and leadership. Each item on the survey is rated on a 5-point scale, with 5 being the most positive (see Chapter 5).

Results from Kansas LEAN will illustrate data obtained from a satisfaction survey. Strength and competence of leadership (average rating = 4.4) and staff (average rating = 4.4) were among the highest rated items by the membership of the initiative. Participation by racial/ethnic minorities (average rating = 3.3) and promoting awareness of the goals, actions, and accomplishments of the initiative (average rating = 3.5) were among the lower rated items. All respondents noted that the community was better off because of Kansas LEAN. The data and qualitative comments from the survey informed leadership about members' perceptions of the functioning of the partnership and challenges to be addressed.

Were the Community Changes Important to Reducing Risks for CVD?

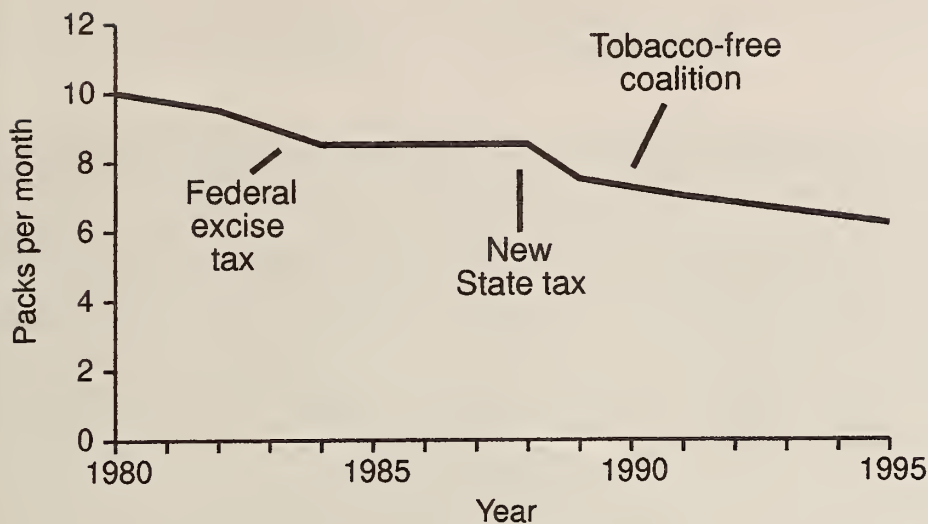
Community changes or accomplishments of the initiative are of unequal importance. We recommend using a constituent survey of outcomes to assess the perceived significance of the community changes facilitated by the initiative that are related to the mission. Members of the partnership and outside experts rate each community change using a 5-point scale, with 5 the highest importance rating and 1 the lowest (see Chapter 6). Note that data on community-level indicators provide a more quantitative assessment of public health significance (see Chapter 8).

Data from an outcome survey for Kansas LEAN will illustrate. Overall, respondents rated community changes facilitated by the project as “Important.” Among the higher rated changes was a supermarket intervention that included price reduction, shelf prompts, and posters (average rating = 4.1). The contribution of all the reported community changes to the mission was also rated positively. The data were shared with initiative leadership and used in future planning. The results were also used to inform funders about the importance of the accomplishments of the state wide coalition.

Does the Initiative Have a Community-level Outcome Related to the Risks for CVD?

Archival records or other indirect, global measures are used to provide data on whether the initiative is having a positive impact on community-level indicators (see Chapter 8). Figure 10.4 provides hypothetical data on the seasonally adjusted trend in per capita consumption of cigarettes (patterned after a similar analysis in California). This figure shows that the new State tax and tobacco-free coalition may have contributed to the downward trend in tobacco use, extending the more dramatic changes that correlated with new federal and State taxes on tobacco products. Data from community-level indicators may be used to demonstrate the level of the problem in the county or State. By tracking these data over the years of the initiative and comparing levels with comparable counties or States we can estimate the overall effect.

Figure 10.4
Trend in the community-level indicator
per capita consumption of cigarettes*



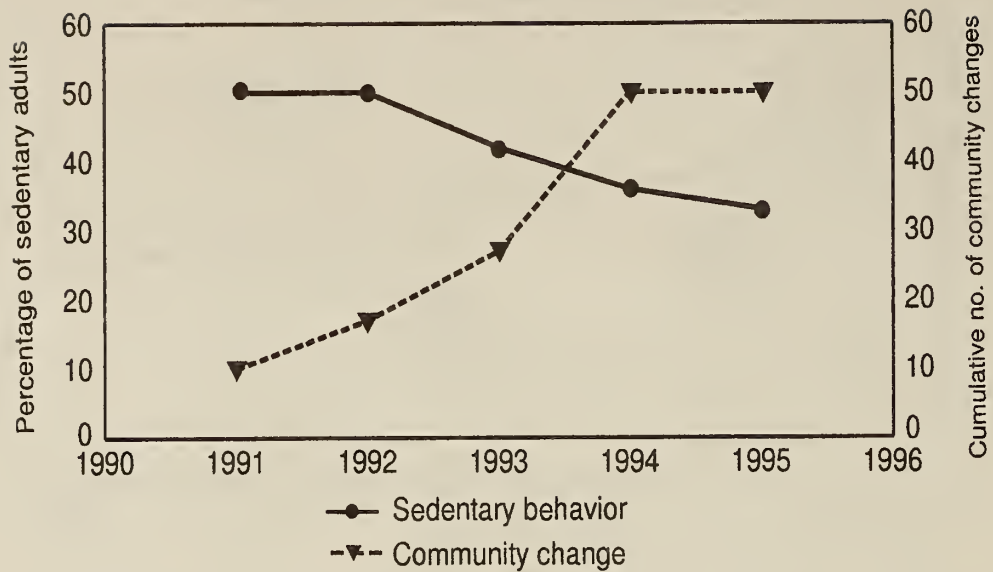
*Seasonally adjusted trend for a hypothetical tobacco-free coalition.

Is Community-level Outcome Related to Changes Facilitated by the Initiative?

Data on both community-level outcome and related patterns of community change may be integrated to examine possible relationships.¹ For example, outcome data on consumption of cigarettes might be overlaid on community changes facilitated by a tobacco control initiative. Possible relationships between community changes facilitated by the partnership and community-level outcome can then be explored.

Figure 10.5 displays data for a hypothetical coalition whose goal is to decrease sedentary behavior. The figure shows community changes related to a community-level outcome of the percentage of adults who are sedentary. Note that a reduction in the percentage of adults who are sedentary occurs only after a sufficient number of community changes accumulated. With a reduction in community change in the final year, no further reductions in the percentage of adults who are sedentary were reported for this hypothetical initiative. This example illustrates how data from the evaluation system can be used to examine possible relationships between system changes facilitated by the initiative and community-level outcomes.

Figure 10.5
Community changes vs. sedentary behavior*



*Data for a hypothetical physical activity coalition.

What Critical Events Seemed to Spur Rates of Community Change?

Semistructured interviews with leaders and active members of the partnership can be used to identify events that were influential to the initiative's functioning. Through analysis of critical events many important factors may be identified such as hiring of staff, monitoring and feedback, action planning, or a transition of leadership (see Chapter 9).

We can explore possible relationships between identified critical events and measures of community actions and community changes. This can be done by indicating the timing of critical events on graphs of community actions and changes. Figure 10.2 displays several critical events identified by a variety of key informants who reported that the events were influential in the functioning of Kansas LEAN. Increases in the rate of community change occurred after introduction of the grant award, completion of action planning, and hiring of additional staff. These factors may have contributed to increases in community change. This process may help identify factors important in the development of initiative. It also helps document the history of the initiative.

Conclusion

This chapter describes how to use this comprehensive evaluation system to examine a variety of key questions about the functioning of CVD prevention initiatives. The next chapter describes how to communicate information about the partnership to secure support from key audiences.

Summary of questions that can be addressed with the evaluation system

- Was the community mobilized to reduce risks for CVD?
- What changes in the community resulted from the initiative?
- Was there a change in behavior related to risks for CVD?
- Were members satisfied with the partnership?
- Were the community changes important to reducing risks for CVD?
- Does the initiative have a community-level outcome related to the risks for CVD?
- Is the community-level outcome related to changes facilitated by the initiative?
- What critical events seemed to spur rates of community change?

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Communicating Information About the Initiative

Leaders and evaluators of the partnership should communicate information about the progress and accomplishments of the initiative with audiences of interest. Local officials and potential funders may be particularly important audiences. Presenting data on the process, intermediate outcome, and more distal outcomes of the initiative communicates to your audience that the initiative has specific goals and is monitoring progress toward achieving those goals. Data presentations also provide opportunities for local, State, and national audiences to learn from and advise the partnership about how to improve.

Communicating data: What and why?

What is it?

- A way to inform local, State, and national audiences of the goals and achievements of the CVD prevention effort.

Why do it?

- At the local level:
 - To help raise awareness of CVD as an issue of concern
 - To help attract volunteers, funding, and in-kind resources from local concerned citizens and agencies
 - To promote recognition of the efforts of volunteers and collaborators
 - To help lobby for local ordinances or program changes to help prevent CVD
 - To provide accountability to the community, trustees, and funders.

Communicating data: What and why? (Continued)

- At the State level:

To create a “name” for the initiative in the State, making it more competitive when seeking State resources

To help establish a statewide network of persons and agencies with similar goals

To help lobby for legislative changes to help prevent CVD

To help the initiative garner recognition and resources from the State and region.

- At the national level:

To create a “name” for the initiative nationwide, which makes it more competitive when seeking resources from the State or Federal government or from private foundations

To help tap into nationwide networks of persons and agencies interested in preventing CVD

To help the initiative garner recognition and resources from across the country

To encourage development of community partnerships to prevent CVD.

- At all levels:

To help keep the issue of CVD prevention on the public agenda and validate partnership strategies as appropriate and worthy of support.

Accomplishments to be highlighted in presentations will likely change over time. Early on, baseline data from behavior surveys and archival records of community-level indicators may help create awareness of the level of the problem of CVD in the community or State. Monitoring data, particularly of community action and change, provide evidence of project activities and accomplishments early in the development of the CVD prevention initiative. Later in the development of the partnership, behavioral data, and community-level indicators will help document improvements in more distal outcomes.

Communicating data: How to's

- Develop a presentation format that can be lengthened or shortened depending on the amount of time available, including compelling descriptions and visuals of:
 - CVD and related risk factors as issue(s) of concern
 - The initiative's goals, strategies, and methods for reaching its goals
 - Data on activities (e.g., services provided)
 - Data on accomplishments (i.e., community changes)
 - Data on outcomes (i.e., behavioral measures and community-level indicators).
- Keep visuals simple to decrease problems interpreting data; the first and last visuals and words should convey your primary findings or message.
- Identify important audiences for the data:
 - Local:* Health organizations, civic organizations, business groups, grassroots organizations, school boards, PTAs, church organizations, editors and editorial boards, newspapers, elected and appointed officials in local government, grantmakers
 - State:* State and regional professional conferences, regional professional training workshops, grassroots and advocacy organizations, health conferences, grantmakers
 - National:* Professional conferences, professional training workshops, grassroots and advocacy organizations, health conferences, grantmakers.
- Identify avenues for getting the word out:
 - Word of mouth
 - Presentations
 - Newspapers
 - Newsletters
 - Radio spots
 - Television coverage
 - Professional journals.

Data should be graphed and shared with the leadership and membership of the partnership. Presenters can share stories and visuals such as photos, project posters, or other materials from project activities. Combining data, visuals, and anecdotes or quotes during presentations is a powerful way to share your message.

Presentations should be tailored to each audience and their particular interests. For instance, activities that contribute to health outcomes may be of particular interest to public health audiences, while service organizations may be especially interested in activities that contribute to community well-being. Furthermore, who presents to each audience may influence how the audience receives the message. For example, lay or community members may reach the audience the best in some settings, whereas in others academic or professional staff members of the initiative or those who represent the business community may be more effective.

Each presentation should have a clear goal or intended outcome. Many presentations will use data and other relevant information to increase awareness of CVD as a health concern and the need for action. *It is important to go beyond increasing awareness.* Presentations can be used effectively to solicit support and involvement of community members in the CVD prevention effort. For example, service organizations may volunteer to assist with project activities or collaborate on a new program. Some national organizations have local chapters that support projects that may be consistent with the mission or provide resources for special projects. Professional organizations such as the American Heart Association and the American Lung Association have expertise in areas that may strengthen the initiative. These national organizations have State and local affiliates that work directly with the public and are active with legislators and other policy makers. Members of State and national organizations may be able to establish changes in policy or practice that will reduce risks for CVD. For instance, local members of the National Recreation and Parks Association have been successful in developing physical activity promotion materials that are used in local health departments. When communicating data, be sure to have a goal or outcome in mind.

Publishing in professional journals is a more formal and time-intensive method of communicating information about the partnership. Forming collaborative relationships with researchers at local colleges and universities may increase access to these forms of communication.

Summary of possible goals of a presentation

- Obtaining money and in-kind resources for the partnership.
- Attracting volunteers for project activities.
- Influencing a change in program, policy, or practice.
- Obtaining input on making the initiative more responsive.
- Overcoming resistance to the initiative.
- Learning how the initiative can become more effective.

Some Reflections on the Evaluation System

This handbook describes a comprehensive evaluation system for community partnerships for preventing CVD.* We described 6 measurement instruments and 13 measures related to understanding and improving the process, intermediate outcome, and more distal outcomes of community health initiatives. Depending on interests, resources, and requirements, a community partnership might use some or all of these measures.

Core measurement instruments

- Monitoring and feedback system.
- Surveys of:
 - Satisfaction
 - Outcome
 - Behavioral surveys
 - Community-level indicators
 - Interviews with key participants.

The data can be used to understand a variety of questions, including whether the initiative is (a) mobilizing the community, as suggested by a steady climb in community action; (b) changing the community, as indicated by new or modified programs, policies, and practices related to the mission; (c) changing behavior, as indicated by data from behavioral surveys; or (d) having more distal outcomes, as indicated by changes in community-level indicators of reduced risks for CVD.

The metric of community change is an especially strong contribution of this evaluation system. Community changes (new or modified programs, policies, or

*Portions of this chapter are adapted from: Fawcett, S. B., Lewis, R. K., Paine-Andrews, A., Francisco, V. T., Richter, K. P., Williams, E. L., and Copple, B. (in press).

practices) are evidence of the initiative's accomplishments. High rates of community change can help create a health-promoting community with reduced risks for CVD.

Exploring the relationship between community change and community-level indicators is important because of the long delay between community changes and positive changes in community-level indicators. The research with Project Freedom of Wichita, Kansas, suggests that community change and community-level indicators may be positively related.¹ Future research is needed, however, to improve understanding of the possible relationship between community change and community-level indicators associated with CVD.

The evaluation system also provides qualitative data on how community initiatives function. Data from surveys assess member satisfaction with the initiative. Interviews with key informants help determine what critical events, such as action planning or the hiring of staff, help community health initiatives function more effectively.

Challenges to evaluating community initiatives to reduce risks for CVD

- Effects are often delayed.
- Difficult to establish links between project activities and particular outcomes.
- May not find a suitable comparison.
- Finding an early marker of more distal outcomes.

Evaluating community initiatives for preventing CVD is challenging for a number of reasons. First, the positive effects of community initiatives are often not shown for many years and may be difficult to track. Facilitating positive change in risk and protective factors is likely to be shown earlier in the development of community initiatives. The evaluation should focus on identifying community changes that will likely reduce risks (or enhance protection) for CVD. The various community changes will not be of equal importance. Surveys and interviews with key informants should be used to secure information about the relative importance of changes to the mission of preventing CVD. The evaluation should remain in place long enough to determine the size and durability of changes in community-level indicators.

Second, determining the relationship between a project's activities (the independent variable) and its effects (the dependent variables) is a common research goal. This may be especially challenging when evaluating community health initiatives. Community initiatives use a variety of strategies, such as advocacy or media, to put in place an array of interventions, such as point-of-purchase prompts for low-fat foods. The interventions target different groups, such as food professionals and parents, and are implemented by different agents, such as religious leaders and business people. They operate in multiple community sectors, such as in schools and businesses, and over different lengths of time. Consequently, clearly identifying the independent variable, its timing, and dose is difficult. The measure of community change provides an important and flexible measure of environmental or systems change.

Third, suitable comparison groups are difficult to secure, however, because changes produced by the partnership often affect the entire population. Obtaining data from (or even finding) similar communities may be difficult. Furthermore, because many communities may also be addressing prevention of CVD, they may serve only as a comparison, but not as an experimental control group. Finding a suitable comparison, although difficult, helps to conclude that the results were due to the initiative and not something else.

Last, identifying early markers of community-level outcomes would allow early and ongoing feedback on the progress of the initiative. As described earlier, community change may predict community-level outcome. However, replication of the possible relationship between community change and community-level indicators is needed. Future longitudinal studies of multiple and diverse initiatives may help determine the conditions under which community change predicts community-level outcome.

The monitoring system addresses some of these issues. However, there are also methodological challenges related to accuracy and sensitivity of reports, measurement reactivity, and instrumentation change. These challenges may be addressed in several ways. First, Event Logs and follow-up interviews with members and staff may increase the accuracy and completeness of reports. Second, honest reporting may be encouraged by occasional verification by independent sources, such as meeting minutes and newspaper articles. Third, a more sensitive reporting system would also note when events are terminated, not only when started. Fourth, there is likely to be a high level of reactivity to the monitoring system. In fact, the system was designed to facilitate reactivity. Because data collection and feedback are part of the design of partnerships using this evaluation system, the observed effects may be limited to those partnerships using monitoring and feedback. Fifth, the evaluation can be expensive and time consuming. Users are encouraged to modify the evaluation (see the “Evaluation on a Shoestring Budget” boxes throughout this handbook).

Finally, changes in instrumentation can be minimized by using the expanded scoring instructions and behavioral definitions found in Chapter 4 and Appendix A. High levels of agreement in scoring among independent observers indicates that the data collected by the monitoring system can be reliable.

Strategies for evaluating community initiatives

- Focus the evaluation on community change, a promising early marker of impact.
- Provide ongoing feedback.
- Assess the significance of changes.
- Ensure data quality through verification and reliability assessments.
- Examine community-level indicators of more distal outcomes.
- Use multiple measures, including quantitative and qualitative data.
- Use qualitative data to examine critical events.
- Replicate the findings in multiple case studies.
- Conduct the evaluation long enough to learn about the size and durability of outcomes.

Even with these challenges, the study of initiatives will likely continue to increase understanding of the development and functioning of community health initiatives. Versions of this evaluation system have been used by researchers from the University of Kansas Work Group on Health Promotion and Community Development with health and human service initiatives in Massachusetts funded by the W. K. Kellogg Foundation and with the Decade of Hope Coalition in Dulce, New Mexico, supported by the Center for Substance Abuse Prevention's Community Partnership Program. With support from the Kansas Health Foundation, there are 11 sites involved in a replication of a substance-abuse prevention model, a school and community initiative for the prevention of adolescent pregnancy, and a rural health promotion initiative. These multiple case studies provide important opportunities for exploring how and under what conditions community initiatives effect community change and community-level outcome. This work and future efforts will test the strength of this model for evaluating community initiatives and its usefulness for supporting community partnerships to reduce risks of CVD.

Few research studies exist that show that an investment in community partnerships had a measurable benefit on community health. Participatory evaluation approaches such as those illustrated by this evaluation system help us understand the factors associated with the functioning of community health initiatives. This information can be used to build and strengthen community capacities to produce change. Collaborative research with community initiatives contributes to societal change and the science that may serve as its foundation.

Summary lessons on evaluation of collaborative partnerships

- The primary purpose of the evaluation is to support improvement, not to judge success or failure.
- Evaluation information can empower community partnerships to further develop and renew themselves.
- Evaluation should begin early and be an integral part of the development process.
- Evaluation should be a participatory and collaborative process.
- A monitoring system can help community leadership establish and maintain effective functioning of the initiative.
- Feedback should be provided at regular intervals, especially early in the initiative's development.
- Evaluation information helps to discover whether the partnership's efforts are actually effective.
- Evaluation information helps direct the initiative's attention to powerful variables that might actually make a difference.
- Evaluation results remind us that behavior change is often slow and dependent on multiple changes in the environment.
- Evaluation results should be communicated openly and frequently to all leadership, membership, trustees, and funding agents.
- Grantmakers can use evaluation information to encourage productivity and accountability.
- Community leadership can use evaluation information to attract and maintain support and resources.

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APPENDICES

APPENDIX A

Background Information and Materials for Using the Monitoring System

Chapter 4 introduced the monitoring system and outlined the five major steps involved in completing the monitoring process. Appendix A provides more detailed information for people responsible for completing the three most complex steps: categorizing log entries, assessing reliability, and graphing and providing feedback on the data generated by the monitoring system.

Categorizing Log Entries

This section addresses:

- General scoring instructions.
- Multiple events in one log entry.
- Duplicate scores.
- Relationship between community action and community change.
- Verifying reported events.
- Record keeping.
- Expanded definitions of categories for scoring.
- Practice exercises and answers.

General Scoring Instructions

This section provides general guidance for deciding which events fit into which scoring category. Categorizing events is not an exact science. As evaluators gain experience classifying events, they may want to make additions to clarify the definitions used to categorize events. Adding examples of events that are difficult to categorize will help others using the monitoring system.

Table A.1 provides a summary of the observational code used to categorize events. It provides a list of categories of key events, definitions, and examples. What is an event? Broadly, events are occurrences that are designed to reduce risks for CVD. The distinction between external and internal events will assist in categorizing key events.

Table A.1
Summary of the observational codes
for the monitoring system

Code	Definition	Examples
External Events (Happens <i>outside</i> the initiative)		
CA Community Actions	Actions taken in the community to bring about a new or modified program, policy, or practice to reduce risks for CVD	<ul style="list-style-type: none">• Letters• Phone calls• Rally
CC Community Changes	New or modified programs, policies, or practices in the community facilitated by the initiative that reduces risks for CVD	<ul style="list-style-type: none">• A new (or modified) program (e.g., nutrition education)• A new (or modified) policy (e.g., labeling low-fat foods)• A new (or modified) practice (e.g., regarding hours of service)
SP Service Provided	Events that are designed to provide information, instruction, or develop skills of people in the community	<ul style="list-style-type: none">• Classes• Workshops• Communications such as bill stuffers
M Media Coverage	Coverage of the initiative or its projects in the newspaper, radio or television, or newsletter	<ul style="list-style-type: none">• Radio• TV (e.g., PSAs)• Brochure
X Other	Items for which no code or definition has been created	

Table A.1
Summary of the observational codes
for the monitoring system (Continued)

Internal Events (Happens <i>within</i> the initiative)		
PP Planning Products	Results, or products of planning activities within the group	<ul style="list-style-type: none"> • Statements of objectives • Formation of committees or task forces with established members • Grant application
RG Resources Generated	Acquisition of funding for the initiative through grants, donations, or gifts in-kind	<ul style="list-style-type: none"> • Materials received • People's time (except volunteers) • Money

External Events. Most of the events will involve people not directly associated with the initiative. For example, staff may work with the city council to approve a new ordinance to ban smoking or may co-sponsor a religious organization's walking group. Both of these events include people from outside the initiative (the city council and walking group organizers and participants) and are considered *external events*. External events can be classified as *community actions*, *community changes*, *services provided*, or *media coverage*. External events involve making things happen in the community to reduce the risks for CVD, which is the purpose of the initiative.

Internal Events. Some events facilitate the development of the partnership or coalition. These events may be internal, involving only those working directly with the group. For example, the Steering Committee may complete their strategic planning process and adopt a formal action plan, or an executive from the initiative's Board of Directors may donate office supplies. *Planning products* (such as the first example), by definition, are always internal events. *Resources generated* (e.g., volunteer's professional time, donated materials, or money) are internal events if the beneficiary is the partnership.

The distinction between external and internal events is helpful, especially in deciding whether the events should be categorized at all. For example, if talk about a proposed policy change occurred only among members of the initiative, not with those who could enact or implement the policy, it would be considered a planning activity, not a community action. If the event involved only those from within the initiative, acting as initiative members, then, to be categorized, the event would need to result in a planning product or generate resources.

Multiple Events in One Log Entry

A single reported entry may contain several discrete events that should be reflected in the scoring by being recorded separately. This is done best by breaking out the one entry into several items and scoring each event separately. For example, the following entry might be recorded on a log form: “The second block party was facilitated in the Pinkney neighborhood. Low-fat foods and recipes were distributed and line dance lessons were given. The event was filmed by the local TV station and appeared in the evening news.” The event is a *service provided*, and the section reporting media coverage would be scored *media*.

Duplicate Scores

There is meant to be little overlap between definitions. For instance, an item may not be scored as both a *planning product* and *service provided*. The category of *community change* is an exception: items scored as community change are usually accompanied by an additional scoring category. The intent of the category of community change is to document all instances of new or modified programs, policies, and practices. But, a new program (such as a workshop) is also scored as a *service provided* (see Table A.1). To capture all of the changes produced, the first new program and the first new practice are scored as *community changes* in addition to another category (*resources generated*, *community action*, *media coverage*, or *services provided*).

The most likely combinations are *community change* and *service provision* (e.g., the first instance of risk assessments conducted at a grocery store chain may be scored as both). *Community change* and *community action* may also be reported as a combined item (e.g., “Committee member met with the hospital director. Routine heart health screenings for family members will now be offered in the waiting rooms”). Only events scored as *community change* can have more than one score.

Relationship Between Community Action and Community Change

Community actions and *community changes* generally relate to each other. Keep in mind the goal or outcome of an action when scoring it. The purpose of a *community action* is to make some change in program, policy, or practice designed to reduce risks for CVD (a *community change*). For each *community action*, the intended *community change* should be evident. A person filling out a log may word items to fit a particular category or definition. The evaluator must code the item relative to what actually happened.

Verifying Reported Events

If the person who scores the logs is different from the person who fills them out, it will be important to spot-check information on the log forms for accuracy. The focus of verification should be on items categorized as *community changes*, because this may be a particularly important marker of program impact.

One way to verify events is to choose several recorded items and call the person(s) involved. You may need to get the phone number from the person completing the logs. If an item that is selected for verification cannot be verified, do not include it when counting items in each scoring category. Caution: this is a highly intrusive method of verification and may suggest mistrust to collaborators.

A less intrusive way of verifying key events is to simply review the logs and check off the events already heard about from independent sources. Another recommended technique is to examine archival records and written evidence such as meeting minutes, newspapers, and newsletters that may be included with the logs.

Record Keeping

There are many ways to archive data collected using the monitoring system. These include storing the logs in a file cabinet, saving logs typed into a word-processing program, or maintaining a computerized database. Keeping records organized is very important. Graphs of the data are only summaries; actual entries of events provides more detailed information.

Entries in the logs should be as complete as possible, especially events categorized as *community changes*. One rule of thumb is to archive *community changes* clearly enough so that someone else reviewing the same entry (years later) would also categorize it as a *community change*. Entries of *community changes* are used in other parts of the evaluation system (see Chapter 6, the Survey of Outcomes). In addition, the list of community changes provides a nice history of the group's accomplishments.

Expanded Definition of Scoring Categories

In the following section, each scoring category summarized in Table A.1 is defined in detail. Entries on monitoring log forms are compared to these definitions to determine which category best describes the entry. For each scoring category, the category is named and abbreviated, a general definition is given, and the criteria that log entries must meet to be included in the category

are presented. The section is outlined using a numbering system to facilitate referencing specific parts of the definition.

1. Community Actions — *Abbreviation: CA.*

General definition: Community actions are actions taken to bring about a new or modified program, policy, or practice to reduce risks for CVD. Events categorized as community actions document the extensive effort it takes to make change in the community.

Project members performing community actions may (a) attempt to modify or create a new program, policy, or practice within the community; (b) implement plans for addressing issues in the community; or (c) attend meetings involving community leaders in which changes are recommended by the member of the initiative.

Community actions include acting directly to make changes in the community, actively lobbying, or advocating with change agents. Personal contacts, phone calls, demonstrations, petitions, and letter writing are all examples of community actions.

- 1.1. Community actions must meet all of the following criteria:
 - 1.1.1. occurred (not just planned);
 - 1.1.2. include community members external to the initiative or outside the committee or subcommittee advocating for change;
 - 1.1.3. be taken to bring about changes in programs, policies, or practices in the community; and
 - 1.1.4. be related to the initiative's goals and objectives.
- 1.2. If presentations to community audiences include generating changes to be made in the community (e.g., listening sessions) or are aimed specifically at some change in the community (relative to the group's mission), then it is a community action. If not, a workshop or other presentation is scored as a service provided.
- 1.3. Collaboration with community members (people external to the initiative) to set new agendas for the community are community actions. If this is the first occurrence of collaboration in the community, however, it could be a community change (a change in practice) as well as a community action.
- 1.4. Actions taken to keep the group going—working on by-laws, soliciting funding for the group, or holding meetings among group members—are not considered to be community actions, since they do not contribute directly to changes in the community to reduce CVD. Internal

meetings among group members are usually not considered community actions.

- 1.4.1. Exceptions occur when members of groups targeted for change are also involved in the initiative and its committees and task forces. For example, at a committee meeting, enforcement issues for selling tobacco products to minors might be discussed with a representative of the police department. Because a representative of a community sector to be changed (i.e., law enforcement) was involved, it would be considered a community action.

Examples of Community Actions:

- A staff member discussed menu changes and offered assistance in developing a heart healthy menu at a local restaurant. (Community action because it facilitates a practice/policy change. See definition 1.1.)
- Merchants were asked to display signs describing the penalty for selling tobacco to minors and the need for proper identification. (Community action because it is directly related to a community change relevant to the mission of reducing risks for CVD. See definition 1.1.)
- Phone calls were made to managers of three area supermarkets to discuss the possibility of placing point-of-purchase signs on shelves indicating items low in saturated fat. (Community action because it is directly related to a community change relevant to the mission of reducing risks for CVD. See definition 1.1.)
- A town meeting was held with residents of the Pinkney neighborhood to discuss how to increase opportunities for physical activity. Ideas generated were added to the project's action plan. (Action taken to generate ideas for community change. See definition 1.2.)

Examples of Items not Scored as Community Actions:

- A meeting was held by the subcommittee for public policy to discuss community policies which may be related to welfare reform. (This is not a community action, since no one external to the initiative, such as a policymaker, was present and it was not part of the mission of the initiative. See definitions 1.1.2, 1.4, and 1.1.4. This entry would be scored "X." X is the abbreviation for the category "Other" for items for which no code or definition has been created).

- The executive director contacted area store managers to arrange a meeting to discuss the goals of the initiative and request their support. (This is not a community action, since the aim was to increase support for the initiative, not community change. See definitions 1.1.3 and 1.4. This entry would be scored X.)
- A meeting was held by the Schools Committee to discuss election procedures for electing the chairperson. (This is not a community action, since it relates to change in the initiative, not the community. See definitions 1.1.2 and 1.4. This entry would be scored X.)
- Representatives of the initiative will contact the local supermarket to arrange a meeting to discuss the implementing point-of-purchase signs. (This item is a future event, not an action that already occurred. See definition 1.1.1. This entry would be scored X.)

2. Community Changes — *Abbreviation: CC.*

General definition: Community changes are new or modified programs, policies, or practices in the community facilitated by the initiative that reduce risks for CVD. Statements of community changes should include information about the impact on the community (e.g., number of stores changing policies). Changes that have not yet occurred, those unrelated to the group's goals, or those which the initiative had no role in facilitating are not considered community changes for the initiative.

2.1. Community changes must meet all of the following criteria:

- 2.1.1. occurred (not just planned);
- 2.1.2. include community members external to the initiative or outside the committee or subcommittee advocating for change;
- 2.1.3. are related to the initiative's chosen goals and specific objectives;
- 2.1.4. are new or modified programs, policies, or practices of governmental bodies, agencies, businesses, and other sectors of the community; and
- 2.1.5. are facilitated by individuals who are members of the initiative or are acting on behalf of the initiative.

2.2. Changes reported at different points in time should be counted as separate changes only if they resulted from different actions.

- 2.3. The first instance of a new program or practice in the community is scored as a community change, since it constitutes a change in a program or practice in the community.
- 2.4. The first occurrence of collaboration between community members external to the initiative is a community change (a change in practice).
- 2.5. Not all first-time events are community changes; the event must meet all parts of the definition of a community change. For example, if staff members attended a seminar for the first time, this is not a community change because it is not a new or modified program, policy, or practice of an organization.

Examples of Community Changes:

- Point-of-purchase signs indicating breakfast cereals low in saturated fat were put in three supermarkets. (Change in practice directly related to group actions and consistent with its mission of reducing risks for cardiovascular disease. See definition 2.1.)
- A video describing healthy nutrition and exercise is now shown daily in the waiting room of the pediatric clinic of the local hospital. (Change in policy directly related to group actions. See definition 2.1.)
- A local business adopted a low-fat menu in their employee cafeteria. (Change in practice directly related to actions by the group. See definition 2.1.)
- An education and skills training program was incorporated into the local high school curriculum. (Change in program directly related to the group's actions and specific objectives. See definition 2.1.)

Examples of Items Not Scored as Community Changes:

- Junior high school students will increase awareness of the effects of diet and exercise on their physical and emotional health. (Outcome written in the future tense. It will only be scored if it already occurred. See definition 2.1.1. This entry would be scored X.)
- A new subcommittee was formed to address federal legislative issues. (This is a planning product, since it reports a change in the organization of the initiative, not the community. See definitions 2.1.2, 2.1.3, and 2.1.4. The score for this entry is X.)
- The project's Administrative Assistant reported that the AME church started a new Sunday afternoon walking group. (As written, the event was not facilitated by the project. See definition 2.1.5. The entry would be scored X.)

3. Planning Products — *Abbreviation: PP.*

General definition: Planning products refer to the results or products of planning activities within the group. There are many types of planning activities, such as developing a mission, completing a strategic planning process, developing an action plan, and setting committee goals. Usually there is some result of planning, something that helps guide the initiative's activities. The result of planning can be, for example, mission statements, strategic plans, written action plans, or written committee goals. These results or products of planning are categorized as planning products. A new initiative will usually complete a number of planning products over time. Most initiatives review and update their action plans yearly.

Planning products can include (a) statements of objectives (including broad goals), (b) formation of committee or task forces (among established members of the initiative), (c) by-laws and rules adopted, (d) grant applications written or submitted, and (e) the hiring of staff for the initiative.

- 3.1. Planning products must meet all of the following criteria:
 - 3.1.1. are identified products or residuals of planning activities,
 - 3.1.2. are completed, and
 - 3.1.3. occurred with only individuals internal to the initiative.
- 3.2. Planning products may create the opportunity for service delivery, gathering and distributing resources, and community actions and community changes.
- 3.3. Separate planning products may be scored if the same item reflects more than one product of planning.
- 3.4. Planning is an internal activity. Collaboration with community members (people external to the initiative) to set new agendas for the community are community actions. One needs to keep in mind that partners often wear two or more hats and can act within the initiative as well as outside the initiative.
- 3.5. Planning products include creation of groups within the initiative, such as committees or task forces for collaborative problem solving.
- 3.6. Hiring staff is an instance of a planning product.
- 3.7. Adopting mission, objectives, action plans, bylaws, or rules are planning products.
- 3.8. Events that lead to and support the resulting planning product (such as planning meeting) are scored as X.

Examples of Planning Products:

- Legislative committee established and members are elected. (Committee formation is a planning product. See definition 3.5.)
- By-laws were formally adopted by the group. (Adoption of by-laws or rules is a planning product. See definition 3.7.)
- Community changes to be sought by the supermarket task force were adopted. The first committee meeting was on 6/2/90. (Adopting objectives is a planning product. See definition 3.7.)
- Broad goals and objectives of the initiative were established at initiative meeting on 7/21/90. (Goal formation is a planning product. See definition 3.7.)

Examples of Items That are Not Planning Products:

- The initiative director drafted goals for the members to review. (This is not a planning product, since the result is yet to be reported. See definition 3.1.2. Entry would be scored as X.)
- A local foundation provided a \$10,000 grant to facilitate an education and awareness program of the initiative. (The grant is a unit of resources generated; the grant application would likely be a planning product. See definitions 3.1 and 6.1.)
- Travel arrangements were made for speakers to present at the October workshop. (This is not a planning product, since it relates to a future service provided. See definition 3.1. Entry would be scored as X.)
- Nutrition education workshops were conducted with local child care providers. (This is a service provided. See definitions 3.1 and 4.1.)

4. Services Provided — *Abbreviation: SP.*

General definition: Services provided are events that are designed to provide information or instruction or to develop skills of people in the community. Services provided include classes, programs, screenings, workshops, publications, and other services or communications (e.g., PSAs and bill stuffers). Records on services provided include the number of classes or programs conducted and the number of participants in those classes/programs.

- 4.1. Services provided must meet all of the following criteria:
 - 4.1.1. are services or communications to educate, inform, enhance skills, or provide support;
 - 4.1.2. are sponsored or facilitated by members of the initiative;
 - 4.1.3. occurred and/or are ongoing; and
 - 4.1.4. be delivered to community members outside of the initiative.
- 4.2. When a new program is initiated, it should be coded as both a community change and a service provided. Any continuing instance of programs are services provided.
- 4.3. If presentations to community audiences include generating changes to be made in the community (e.g., listening sessions) or are aimed specifically at some change in the community (relative to the group's mission), then it is a community action. If not, a workshop or other presentation is scored as a service provided.
- 4.4. Instances of service provision (e.g., each workshop, class, or program) are scored each time the event occurs.
- 4.5. Events to plan services (such as meetings to decide the content of a class) are scored as X.

Examples of Services Provided:

- A press conference on nutrition was held at Dillon's Grocery Store #65 and attended by approximately 100 people. (This is a service provided, since it provided an educational opportunity related to the project's mission. See definitions 4.1 and 4.3.)
- A skills training workshop was conducted at the school. (This is a service provided, since it is a workshop related to reducing risks for CVD. See definitions 4.1 and 4.4.)
- Nutrition education workshops were conducted by child care providers. (This is a service provided, since it is a workshop related to reducing risks for CVD. See definitions 4.1 and 4.4.)
- A conference on diet and exercise programs in area businesses was conducted on 6/27/90. (This is a service provided, since it is an educational program related to reducing risks for CVD. See definitions 4.1 and 4.4.)

Examples of Items Not Scored as Services Provided:

- A mailing list of potential conference attendees was developed. (This is planning for a service that has yet to result in a conference. See definitions 4.5 and 4.1.3. This item would be scored X.)
- Nutrition education workshops will be conducted in the month of March. (This service has not yet occurred. See definition 4.1.3. This entry would be scored X.)

5. Media Coverage — Abbreviation: M.

General definition: Coverage of the initiative or its projects in the newspaper, radio or television, or newsletter. These may be scored as (a) instances or discrete occurrences of coverage, (b) column inches of coverage (for print media), and/or (c) minutes of coverage (for broadcast media).

5.1. Media coverage must meet all of the following criteria:

- 5.1.1. occurred (not just planned);
- 5.1.2. be an instance of radio time, television time, newspaper article, brochure or newsletter; and
- 5.1.3. feature, or be facilitated by, the initiative.

5.2. Record the number of instances and the extent of coverage (i.e., column inches of print media or minutes of broadcast media) for each media exposure. For TV and radio, every airing of a PSA, news report, or event in which the initiative or one of its programs is mentioned is counted as a discrete instance and/or in broadcast minutes. Every newspaper article mentioning the initiative or program is counted as an instance. Every newsletter article is an instance. Each different brochure disseminated is an instance.

5.3. Media coverage is counted if it features the project, even if the coverage was not initiated directly by the group. Airings and articles not facilitated by the initiative are valid only if the name of the initiative or one of its projects or products is mentioned or referred to.

5.4. Count all instances of media coverage facilitated by the initiative. The initiative may facilitate media coverage in a number of ways; for example, by writing PSAs, contacting editorial boards, building relationships with reporters, or sponsoring media events.

- 5.5. Copies of print media should be attached to and stored with the logs.
- 5.6. Internally produced media (such as newsletters and newsletter articles) are all counted as media coverage.

Examples of Media Coverage:

- Newspaper article describing the initiative totaling 15 inches of space. (Scored as 1 unit and/or 15 column inches. See definitions 5.1 and 5.2.)
- Five 10-minute radio spots describing the project aired on the local AM radio station. (Scored as 5 units and/or 50 broadcast minutes. See definitions 5.1 and 5.2.)
- Eight 3-minute radio spots describing the project aired on the local FM station. (Scored as 8 units and/or 24 broadcast minutes. See definitions 5.1 and 5.2.)

Examples of Items Not to be Considered as Media Coverage:

- An article on a teen parenthood prevention project in Washington, DC, public schools appeared in the local newspaper on 9/12/93. (This is not an instance, since the program was not connected to the initiative. See definitions 5.1.3 and 5.3. This entry would be scored X.)
- The local health department developed and distributed a free brochure on preparing healthy meals for children on October of 1993. (This is not an instance, since the brochure was not facilitated by the initiative. See definition 5.1.3. Entry is scored X.)

6. Resources Generated — Abbreviation: RG.

General definition: Acquisition of funding for the initiative through grants, donations, or gifts in-kind. Each separate grant or donation is considered to be a unit of resources generated. Resources generated can include money, materials, and people's time.

The monitoring system counts resources generated in two ways: units and estimated value. Why count resources in two ways? Many initiatives will have a few large grants and many small donations. Counting units (or instances) of resources generated highlights the small donations that would seem inconsequential in dollar amount when compared to the larger grants. These small donations show community support, however, and are important to the long-term financial sustainability of the initiative.

- 6.1. Resources generated must meet all of the following criteria:
 - 6.1.1. occurred (not just planned);
 - 6.1.2. be in the form of money, materials, or donated professional time;
 - 6.1.3. be used to facilitate actions related to the mission of the initiative; and
 - 6.1.4. be allocated to the initiative (not one of its partners).
- 6.2. Donation of people's time is counted if the person is doing work they are trained to do. Professional services of builders, nurses, teachers, and facilitators are examples. Estimate the value of the donated time by calculating the hourly market value of the services multiplied by the number of hours of service.
- 6.3. Estimate the market value of donated materials. For example, if the newspaper donated advertising space for a special event, determine the market value of that advertising space.
- 6.4. Count grant moneys when they are disbursed. For example, if a 5-year \$500,000 grant was awarded and disbursed at \$100,000 per year, count one instance of \$100,000 every year over the grant period.

Examples of Units of Resources Generated:

- The initiative was awarded a \$1,000 grant from Kansas Action for Children. (New grant received. See definition 6.1.2.)
- Funding was received from a foundation to implement nutrition education programs (Money generated with help from the initiative for its projects. See definition 6.1.)
- A portion of a staff member's time (0.5 full-time equivalent) was assigned to the partnership from the county health department (Staff time was donated. See definitions 6.1.2 and 6.2.)
- A three-year implementation grant was awarded by the Kansas Health Foundation. (New grant is a resources generated. See definitions 6.1 and 6.4.)
- A local physician volunteered her time to conduct Heart Health Checks at a project-sponsored conference. (Donation of a person's professional time is a resource generated. See definition 6.2.)

Example of Items That Are Not Units of Resources Generated:

- The fund-raising committee submitted a grant proposal to the Governor's Office. (This is a planning product, since it has not yet resulted in a grant. See definitions 6.1.1. and 3.1. Entry would be scored X.)
- Project staff assisted with writing a grant for the YWCA to secure funds to build a new track. (The money was not allocated to the initiative. See definition 6.1.4. Obtaining this grant may be a community change.)
- Thirty volunteers assisted with the project-sponsored 10-K run. (Volunteers did not donate professional time, according to this entry. See definition 6.2. This entry would be scored X or services provided if it is the only report of the project sponsored run.)

7. Not Scored, Other — Abbreviation: X.

General definition: Other items included on the logs for which no code or definition has been created. If this occurs, code the item X.

New initiatives will often report activities that are in process. Much of the monitoring system, however, is designed to track the results of actions, such as media coverage, services provided, and resources generated. Clearly there are many activities that will take place before a result is produced; for example, phone calls, planning meetings, and confirmation memos. These activities, however, are not categorized in this system.

7.1. If an item is scored as an “X”, it is not also scored as something else.

Practice Exercises and Answers: Assigning Scoring Categories

Included on the next few pages are practice logs and answer sheets for feedback on practice scoring. Following are Event Logs (Figure A.1) and answer sheets (Figure A.2) and Services Provided Logs (Figure A.3) and answer sheets (Figure A.4). Entries in the Media Coverage and Resources Generated logs are usually straightforward, so practice logs are not included. Practice is one of the best ways to learn the monitoring system. Entries listed further on in the logs are more complicated than those listed in the beginning. Answers and explanations are provided after each practice log (Figures A.2 and A.4).

To perform these exercises, follow these instructions. Assign scoring categories to each entry using the Expanded Definitions. Make a photocopy of the logs and write your score in the column labeled “Code.” Compare your scores with the answers provided following the sample logs. The practice logs are written to

simulate logs you may actually receive, so watch out for entries that fall into more than one category, entries that are not scored (e.g., are coded X), and entries on the wrong forms. The monitoring system isn't perfect, so practice won't make you score perfectly, but it will help increase your accuracy!

Figure A.1
Practice Event Log

			Event	Description
Entry No.	Code (CA, CC, PP, SP, M, RG, or X)	Date	Describe the event in detail. Include: a. Why is it important? b. What happened as a result?	a. Who was involved? b. What organizations were collaborators? c. What community sector or objective does this relate to? d. Was this the first time this event happened?
1.		1/1/95	Discussed enhancing physical activity levels and nutrition education in the after-school program at El Centro. Staff will consider making changes.	a. El Centro staff and Jose Mendosa, coalition member b. El Centro c. Broader community d. No
2.		3/1/95	Met with El Centro staff. Physical activity and nutrition components were added to the after-school program.	a. El Centro staff and Jose Mendosa, coalition member b. El Centro c. Broader community d. Yes
3.		2/6/95	Met with the manager of a chicken place and discussed adding low-fat items to their menu. She agreed to contact the franchise office to see what foods can be offered.	a. Manager of restaurant and staff b. Chamber of Commerce c. Business community d. Yes
4.		2/9/95	Presented on the topic of lower fat eating strategies at the local AARP meeting. 16 people attended. They asked great questions about cooking techniques.	a. Coalition member Kristie arranged, Chef Jones presented b. AARP c. Broader community d. Yes

Figure A.1
Practice Event Log (Continued)

			Event	Description
Entry No.	Code (CA, CC, PP, SP, M, RG, or X)	Date	Describe the event in detail. Include: a. Why is it important? b. What happened as a result?	a. Who was involved? b. What organizations were collaborators? c. What community sector or objective does this relate to? d. Was this the first time this event happened?
5.		3/3/95	Wrote an editorial on our need for bike paths along the river. The editorial will be featured in Sunday's <i>Herald Times</i> .	a. Media Task Force member Ella wrote it b. YWCA helped with the research c. Broader community d. First time Ella wrote one
6.		2/1/95	Tonya, Associate Professor at Haskell Indian Nations University, donated 2 hours of her time analyzing the BRFSS's data for the Pinkney neighborhood.	a. Tonya b. Haskell c. Not sure d. No
7.		1/8/95	Met with parents from the Waldorf school to finalize school snack and lunch menus. Parents rewrote the menu to include lower fat and higher fiber foods. New menus are being used and the kids are eating most of the food!	a. Parents and staff b. Nutritionist on Health Task Force helped c. School sector d. Yes, for the Waldorf school
8.		2/4/95	Met with St. John elementary school and School Food Service director and discussed changing the school food program. He is going to talk to the principal and we will meet again next week.	a. Staff b. St. John school c. School sector d. Yes

Figure A.1
Practice Event Log (Continued)

			Event	Description
Entry No.	Code (CA, CC, PP, SP, M, RG, or X)	Date	Describe the event in detail. Include: a. Why is it important? b. What happened as a result?	a. Who was involved? b. What organizations were collaborators? c. What community sector or objective does this relate to? d. Was this the first time this event happened?
9.		2/5/95	Arranged a meeting with the Chamber of Commerce and MAS (Mothers Against Smoking). This is the first time these groups have met. MAS asked business leaders to adopt at least one practice change that would make cigarettes more difficult for youth to obtain. They were really interested. We scheduled another meeting to formalize agreements.	a. MAS, the Chamber, and staff b. See above c. Business community and broader community d. Yes
10.		2/6/95	The project held a community-wide listening session to hear people's concerns about secondhand smoke. Community member's ideas were added to an action plan to address the problem.	a. 36 community members and all staff b. Community building donated space c. Broader community d. First on this topic
11.		2/7/95	The Health Organizations Task Force met. Discussed priorities and leadership needs. Scheduled meetings for next 6 months.	a. Task Force members b. None c. Health Organizations d. No

Figure A.1
Practice Event Log (Continued)

			Event	Description
Entry No.	Code (CA, CC, PP, SP, M, RG, or X)	Date	Describe the event in detail. Include: a. Why is it important? b. What happened as a result?	a. Who was involved? b. What organizations were collaborators? c. What community sector or objective does this relate to? d. Was this the first time this event happened?
12.		2/9/95	Worksite Task Force meeting was held. Joe, who is in charge of PR at the hospital, agreed to include the project's brochure, "Heart Health Tips" on all meal trays. The brochures are now put on trays during the first week of every month.	a. Task Force members b. None c. Health Organizations d. No, they meet monthly
13.		2/9/95	Superintendent of Haskell Indian Nations University told me at church that they changed the school policy to require physical education, stressing lifelong exercise, for all students.	a. Haskell Indian Nations University b. None c. Schools d. Yes

Figure A.2
Answer sheet for practice Event Log

Entry No.	Correct Code(s)	Explanation	Definition No.
1.	CA	The purpose of this meeting is to change the after-school program, which is a change in El Centro's practices. The score of community change, however, is not appropriate because the change has not happened yet. The meeting is a precursor to the desired community change.	1.1
2.	CA and CC	The change discussed in #1 happened and is scored CC. The meeting reported in this entry is scored as CA because it meets all the criteria listed in 1.1. Most community changes are accompanied by an additional score, usually CA or SP.	2.1 and 1.1
3.	CA	The purpose of this meeting is to change the menu, which would be a change in a Chicken Place practices. As with #1, the change has not happened yet. Notice that the recorded answered "yes" to the question "Was this the first time this event happened?" Answers to this question can be misleading. This may be the first meeting with the restaurant, but not the first instance of a change in program, policy, or practice.	1.1 and 2.1.1
4.	SP	The purpose of this event is to inform people about eating less fat, which falls under the category of services provided. Notice that this service was put in the event log. The event log is designed to record community actions and community changes, but it may be used to report events that fall in other categories.	4.1.1
5.	X	The purpose of writing the editorial is to produce media coverage. After it has been published, the editorial will be an instance of media coverage.	5.1.1
6.	RG 1 unit \$70	Tonya donated her professional time, which is an instance of resource generation. The value of her time was estimated at \$35.00 per hour. A telephone call to determine the going rate for a service or an educated guess can be used to estimate value of someone's time.	6.2

Figure A.2
Answer sheet for practice Event Log (Continued)

Entry No.	Correct Code(s)	Explanation	Definition No.
7.	CA and CC	The Waldorf school changed the practice involved in preparing food for the children at school, which is a community change. The meeting to make this change is scored as a CA.	1.1 and 2.1
8.	CA	The purpose of the meeting is to change the food service practices at St. John school. The change has not happened yet.	1.1
9.	CC and CA	This is another example of a number of events in one entry. Two new groups collaborated to make changes in the community. The new collaboration is a change in practice and is scored as a community change. The meeting itself is a CA.	2.4 and 1.1
	CA	MAS and the initiative requested that businesses adopt new practices making cigarettes more difficult for youth to obtain. The purpose of the request is a practice change that has not yet happened.	1.1
10.	CA	The purpose of this presentation is to gather information from community members to make changes related to reducing secondhand smoke. Ideas were added to the group's action plan.	1.2
	RG 1 unit \$30.00	The community building space was donated. The donation is an instance of a resource generated. Donation was estimated to be valued at \$30.	6.3
11.	X	This was an internal meeting. The meeting did not result in any planning products.	1.4 and 3.8
12.	CA and CC	This was an internal meeting. It is different from #11 in that a Task Force member was acting in the role of PR coordinator for the hospital. A community change occurred during the internal meeting.	1.4.1 and 2.1
13.	X	As reported in this entry, the coalition did not facilitate this community change.	2.1.5

Figure A.3
Practice Ongoing Services Provided Log

Entry No.	Code	Date	Service (e.g., workshop, class, screening)	Location	No. of People Attending	No. of Hours	New Service? (Yes/No)
1.		1/1/95	Cholesterol screenings	Northridge nursing home	76	5	No
2.		3/1/95	Cool Guys Thursday Night walk-in group	Hard Rock Cafe	16	1	No
3.		2/6/95	Cook-off featuring low-fat ethnic foods	Southwest AME church	134	3	No
4.		2/9/95	Presented on the mission of the project and evaluation data to the United Way board of directors	United Way	5	1	Yes
5.		3/3/95	Presentation to MADD on steps they can take to increase enforcement of Synar ordinances (no sales to minors). Will meet next week to develop a collaborative action plan.	Home of Mary Mathews	15	1	Yes
6.		2/1/95	Presented tips on how to increase time spent in lifelong aerobic physical activities in high school PE classes to a group of PE teachers. Principal is interested in changing PE class curriculum and wants PE teacher's support.	Jackson High School	35	2	No
7.		1/8/95	Smoking cessation support groups for pregnant teens held on Tuesday and Thursday	Johnson High School and Bryant High School	Tu-5 Th-7	1	No
8.		2/4/95	First Annual breast cancer walk-a-thon	Downtown	360	4	Yes
9.		2/6/95	Met with SADD chapter members to plan next STOP class	Office	3	1	No

Figure A.3
Practice Ongoing Services Provided Log (Continued)

Entry No.	Code	Date	Service (e.g., workshop, class, screening)	Location	No. of People Attending	No. of Hours	New Service? (Yes/No)
10.		2/8/95	Lawrence Memorial Hospital sponsored 6 smoking cessation classes	LMH	?	?	Yes
11.		3/7/95	Presented the injury prevention advantages of designated bike paths to a local physician's group. They decided to cosponsor a local ordinance supporting bike paths.	LMH	6	2	Yes

Figure A.4
Answer sheet for practice Ongoing Services Provided Log

Entry No.	Correct Code(s)	Explanation	Definition No.
1.	SP	The purpose of the screenings was to provide information about cholesterol levels and general education on risk reduction.	4.1
2.	SP	The purpose of the group is to provide support for participating in physical fitness activities.	4.1.1
3.	SP	The purpose of the cook-off is to enhance people's skills in low-fat cooking.	4.1
4.	SP	At first glance the event looks like it might be a community action. The presentation, however, was not interactive nor aimed specifically at some community change; therefore it is not a community action.	1.2 and 4.1
5.	CA	The presentation was aimed at a specific community change, enforcement of an ordinance; therefore the event is a community action.	1.2
6.	CA	This event is similar to #5. The purpose is to change the practice of PE teachers.	1.2
7.	SP and SP	Support groups are services. Note that two services are reported in one entry.	4.4
8.	CC and SP	The walk-a-thon is a new practice in the community and is therefore scored as a community change and service provided.	2.1 and 4.2
9.	X	Planning for services is not a service provided even if people external from the group participate in class preparation.	4.5
10.	X	This entry suggests that the initiative did not sponsor or facilitate the classes.	4.1.2
11.	CA	The purpose of the presentation was to secure support for a specific community change; it is therefore a community action.	1.2 and 4.3

Assessing Reliability of Scoring

This section addresses:

- Steps for assessing reliability.
- What to do with low scores.
- Examples.
- Practice exercises and answers.

Steps for Assessing Reliability

Some partnerships may intend to publish or make conference presentations of monitoring data. In these circumstances, it may be important to assess reliability on the scoring of coded logs. Reliability refers to whether independent observers score events in the same way. For those initiatives with few resources or less stringent requirements for evaluation, assessing reliability may be unnecessary.

There are only three steps taken to calculate reliability: scoring, filling out a reliability table, and calculating the agreement score.

Step 1: Two People Score the Same Set of Logs. Two people independently categorize the same log forms. One person acts as a primary observer and one is a reliability observer. A reliability observer is someone who independently scores logged events to ensure that events are coded accurately in accordance with the written, agreed-upon definitions. If new definitions or categories are developed or revised based on discussions between the primary and reliability observers, recode the logs separately and recalculate reliability (you may have to go back to the beginning of the logs). A random sample of items may be used for reliability for those months when many logs are returned (10% to 20% would be reasonable, although evaluators might do 100% for the first few months of the evaluation).

Step 2: Fill Out a Reliability Table. The primary observer obtains the scored logs from the reliability observer and compares them with his or her own by using a reliability table. The reliability table can be as simple as a table listing each event and the codes of both observers. The codes are compared, and agreements and disagreements are noted.

Step 3: Calculate the Reliability Score. Reliability scores range from perfect agreement (100%) to complete disagreement (0%). Researchers disagree on the range of acceptable levels of reliability, but scores over 80% are generally accepted. There are a number of formulas that can be used to calculate reliability. The following formula assesses reliability generously. A more conservative formula may be used if the data are shared with scientific audiences.

A reliability score can be calculated by totaling each cell in the reliability table and using the formula:

$$\text{reliability score} = (\text{no. of agreements} / \text{total no. of coded events}) \times 100$$

What To Do If Your Reliability Scores Are Low

Lower rates of reliability are expected at first. Don't worry: with practice reliability scores will probably increase. If not, discuss events difficult to score with the reliability observer. Try to reach consensus on the appropriate category for these events. Add these events difficult to score under examples in the monitoring definitions. If, after practicing and talking, reliability scores are still low, consider assigning someone with the role of "expert." The expert should have the best grasp of the definitions. Everyone else can then try to calibrate their scores to the categories assigned by the expert. If all else fails, modify the definitions or add new categories.

Example: Calculating Reliability

Helen scores this initiative's logs regularly; she is the primary observer. Vince, who has been scoring logs from another initiative, codes the same set of logs to assess the accuracy of their coding. Vince is the reliability observer. The scores from both of them are listed in Figure A.5.

Figure A.5
Codes for example set of logs

Event	Helen's Code	Vince's Code	Agreement or Disagreement
1	CA	CA	A
2	CA	PP	D
3	CA	CA	A
4	CA	X	D
5	SP	CA	D
6	CC	CC	A
7	SP	SP	A
8	SP	SP	A
9	SP	SP	A
10	SP	SP	A
11	SP	SP	A
12	X	X	A
13	M	M	A
14	CC	CC	A
15	M	M	A
16	X	X	A
17	CA	X	D
18	CA	SP	D
19	CA	CA	A
20	CA	CA	A
21	X	X	A
22	X	X	A
23	CC	CC	A
24	X	X	A
25	X	X	A
26	RG	RG	A
27	RG	RG	A
28	X	X	A
29	M	M	A
30	M	M	A

The column on the far right in Figure A.5 indicates Helen and Vince's agreement or disagreement on which category the event should be assigned: "A" indicating agreement and "D" for disagreement. To calculate reliability, the total number of agreements is divided by the number of agreements plus disagreements and the result is multiplied by 100.

Helen and Vince scored 25 of the events the same. They scored a total of 30 events.

The reliability of their scores is calculated as follows:

$$\text{reliability score} = (25/30) \times 100.$$

Helen and Vince obtained a reliability score of 83.3%, an acceptable level of reliability.

Practice Exercises and Answers: Assessing Reliability

The exercises in this section will give you practice in taking two people's scores for a set of logs and calculating the reliability of their scoring. To perform these exercises, follow these instructions. Indicate if the primary and reliability observer agreed or disagreed on the score they assigned to each event in Figure A.6. Use the formula provided in this chapter $([\text{no. of agreements} / \text{total no. of events}] \times 100)$ to calculate the reliability score.

Figure A.6
Codes for practice exercises

Event	Codes of Primary Observer	Codes of Reliability Observer	Agreement or Disagreement
1	SP	CA	
2	CA	PP	
3	CA	CA	
4	CA	X	
5	SP	CA	
6	CC	CC	
7	X	CC	
8	CC	CC	
9	SP	SP	
10	CA	CA	
11	SP	SP	
12	X	X	
13	M	M	
14	CC	CC	
15	M	M	
16	X	X	
17	SP	SP	
18	X	X	
19	M	M	
20	CA	CA	
21	X	X	
22	X	X	
23	CC	CC	
24	X	X	
25	X	X	
26	RG	RG	
27	RG	RG	
28	X	X	
29	CC	CC	
30	M	M	

Complete the following information and calculate the reliability score below.

- Number of agreements: _____
- Total number of events (agreements + disagreements): _____
- Reliability score (percent agreement): _____

Now compare your responses with the correct answers below.

- Number of agreements: 25
- Total number of events: 30
- Reliability score (percent agreement): 83.3%

Graphing and Providing Feedback

This section provides:

- Steps for graphing and providing feedback.
- An example.
- Practice exercises and answers.

Steps for Graphing and Providing Feedback

After a set of logs is completely coded, the evaluators graph the data. In assessing reliability, it is important to graph only the primary observer's scoring categories. There are many ways of graphing, but the best way is to display it so that people understand it. This will take some trial and error with each particular initiative. (Line graphs, bar graphs, colored lines, etc., are all possible). Graphs can be constructed by hand or with a computer.

We recommend preparing cumulative line graphs, as shown in Figure 4.5. By adding new events to previous ones, cumulative graphs provide a picture of ongoing development of the initiative. The slope of the line is an indicator of how much activity or accomplishment occurs. The steeper the slope, the more activity; a flat line shows no activity.

Graphing is quite easy, but it can be time consuming. Constructing graphs by hand is tedious, and learning a new computer program requires an initial time investment. Graphs are worth the time! After recording and categorizing all these events, why stop short of the most informative and useful product? Graphing makes the data collected easier to understand and provides a way to organize years of data.

Graphing and providing feedback is a three-step process. First, tally scores by category and add the number to the previous months' data. Second, graph the total number of events in each category. Finally, share and discuss the graphs with members of the initiative and community members.

Step 1: Tally Scores and Add to Previous Data. Add up the number of events in each category (e.g., number of community actions and number of community changes) scored in the current set of logs. Note that it is important that only the data from the primary observer are graphed. Otherwise, the data will be distorted and the reliability scores will be meaningless. Enter the numbers on a tally sheet that contains similar data from previous sets of logs.

Step 2: Graph the Data. Locate the point on the graph that represents the cumulative number of each category, draw a dot, and connect the new dot to the dot that represents the previous total. That's all there is to it.

Step 3: Feed Data Back to Members of the Initiative. Once the graphs are completed, make a list of the community changes, and lists of items for any of the other codes, for the current logs. These lists are extremely helpful for those explaining the graphs and saves them the trouble of reading logs that may not contain many actions or outcomes. The lists should be updated monthly, and outcomes should be grouped by month.

Share the graphs with staff from the initiative and community members.

**Presentation of monitoring graphs
should include the following**

- Introducing the coding categories: provide examples of each category and state why this measure is important.
- Pointing out what is positive about the data.
- Noting trends in the line and explaining the possible meaning of the trends.

Example: Graphing and Providing Feedback

Data from Helen's scores (taken from Figure A.5) are used to illustrate how to graph data cumulatively.

Figure A.7 shows an example tally sheet. Data for each month are listed on the row marked "cum." for cumulative. Monthly data are added to the previous month's data in this row. For example, there were 8 community actions in August. Eight was added to the cumulative total of 30 in July for a new cumulative total of 38 in August.

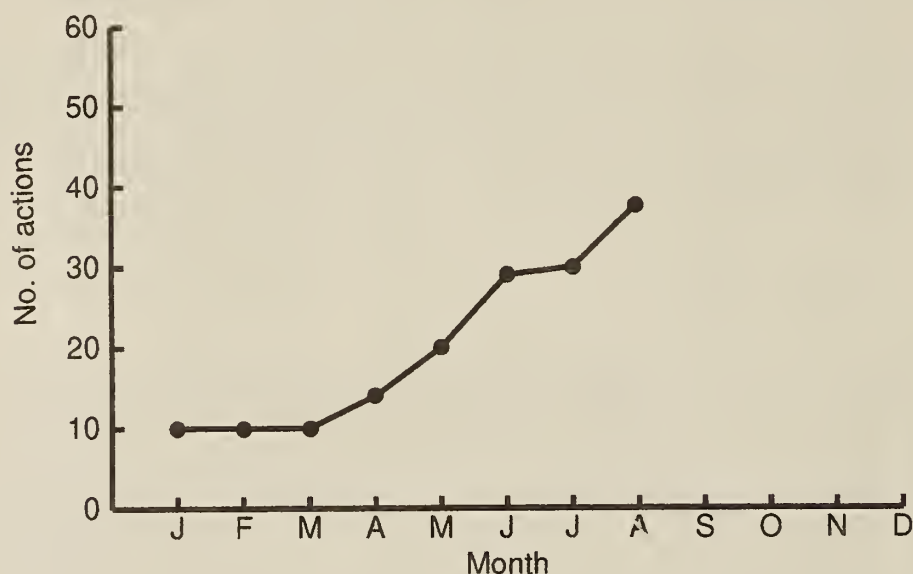
Figure A.7
Example Tally Sheet

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
CA	No.	10		4	6	9	1	8				
	Cum.	10	10	14	20	29	30	38				
CC	No.	0	0	1	1	2	4	3				
	Cum.	0	0	1	2	4	8	11				
SP	No.	0	3	4	6	7	3	6				
	Cum.	0	3	7	13	20	30	36				
PP	No.	4	4	2	0	1	2	0				
	Cum.	4	8	10	10	11	13	13				
Media	No.	5	5	2	3	1	0	4				
	Cum.	5	10	12	15	21	0	25				
RG \$	No.	100,000	0	0	100	20	30	350				
	Cum.	100,000	100,000	100,000	100,100	100,120	100,720	100,750	101,100			
RG units	No.	1	0	0	2	1	1	2				
	Cum.	1	1	1	3	4	11	13				

Cum. = Cumulative

Figure A.8 shows a cumulative graph of the community actions tallied in Figure A.7. Notice the flat line between January and March. In cumulative graphs, flat lines indicate no activity: no community actions were produced in February and March. The line becomes steeper starting in April and continuing through August, which indicates more community actions were produced during that period.

Figure A.8
Example graph of community actions plotted cumulatively



Practice Exercises and Answers

The exercise that follows provides practice in summarizing and graphing four months of monitoring data. Figure A.9 lists sample scoring categories for September–December. Use the Tally Sheet provided in Figure A.10 to calculate cumulative totals for these months. Graph the results, for community changes only, on Figure A.11. Finally, provide answers to questions about the graph.

Figure A.9
Sample data for practice exercise

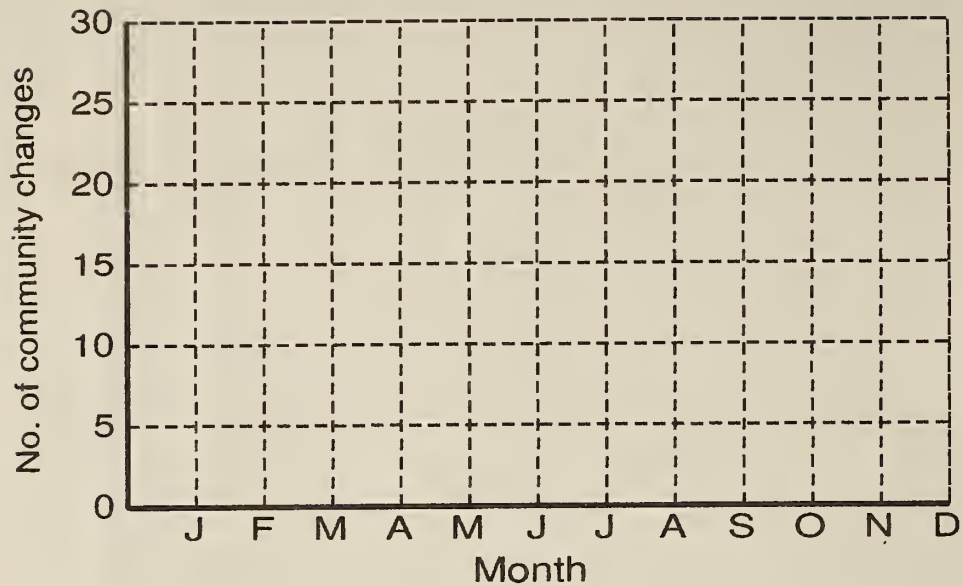
Sept.	PP	CC	CC	CA	CA	CA	SP	SP	CC	M	M	CC	CA
Oct.	CA	SP	SP	SP	CA	CA	CC	CC	CC	CC	M	CA	CA
Nov.	CC	CC	SP	SP	SP	CA	CA	CA	CA	CA	M	M	M
Dec.	CC	SP	SP	SP	CA	CA	PP	SP	SP	SP	SP	CC	CC

Figure A.10
Tally Sheet for practice exercise

		Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
CA	No.	10	0	0	4	6	9	1	8				
	Cum.	10	10	10	14	20	29	30	38				
CC	No.	0	0	0	1	1	2	4	3				
	Cum.	0	0	0	1	2	4	8	11				
SP	No.	0	3	4	6	7	7	3	6				
	Cum.	0	3	7	13	20	27	30	36				
PP	No.	4	4	2	0	0	1	2	0				
	Cum.	4	8	10	10	10	11	13	13				
Media	No.	5	5	2	3	5	1	0	4				
	Cum.	5	10	12	15	20	21	0	25				
RG \$	No.	100,000	0	0	100	20	600	30	350				
	Cum.	100,000	100,000	100,000	100,100	100,120	100,720	100,750	101,100				
RG units	No.	1	0	0	2	1	6	1	2				
	Cum.	1	1	1	3	4	10	11	13				

Cum. = Cumulative

Figure A.11
Graph for practice exercise



Looking at the graph you constructed on community changes, answer the following questions.

Are there any flat points on the line representing community changes? If so, during which months? _____

Are there any steep slopes on the line representing community changes? If so, during which months? _____

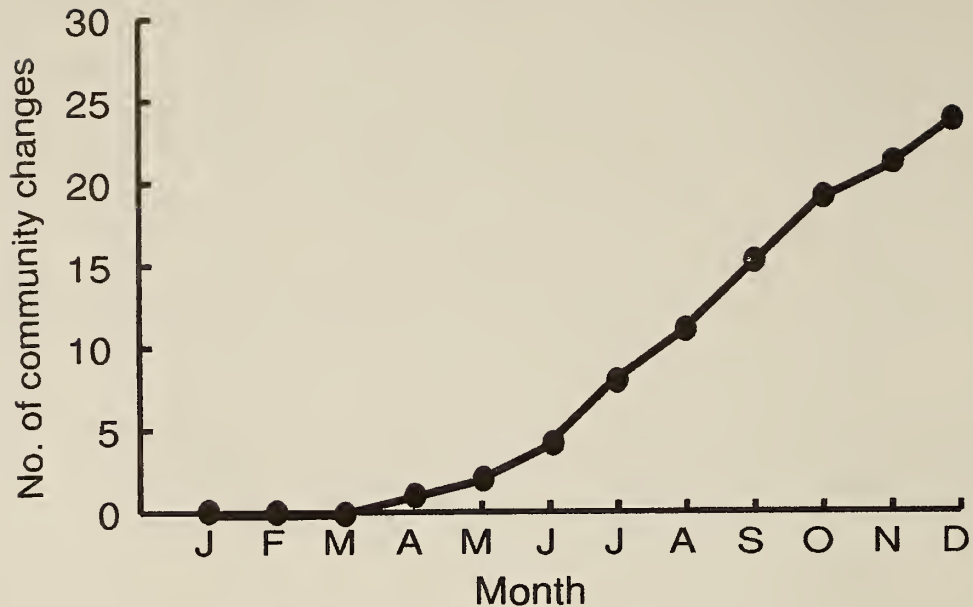
What conclusions can you draw about community changes facilitated over this period?

Figure A.12
Answer Tally Sheet for practice exercise

		Sept.	Oct.	Nov.	Dec.
CA	No.	4	5	5	2
	Cum.	42	47	52	54
CC	No.	4	4	2	3
	Cum.	15	19	21	24
SP	No.	2	3	3	7
	Cum.	38	41	44	51
PP	No.	1	0	0	1
	Cum.	14	14	14	15
Media	No.	2	1	3	0
	Cum.	27	28	31	31
RG	No.	0	0	0	0
	Cum.	101,100	101,100	101,100	101,100
RG units	No.	0	0	0	0
	Cum.	13	13	13	13

Cum. = Cumulative

Figure A.13
Answer graph for practice exercise



Are there any flat points on the line representing community changes? If so, during which months? *There is a flat line from January through March.*

Are there any steep slopes on the line representing community changes? If so, during which months? *Steepest part of the line is between July and October.*

What conclusions can you draw about community changes produced over this period? *No community changes were produced at the beginning of the year. Perhaps this is a new initiative. The first community change happened in April, and there is a steady increase of community changes produced until November. There was a slight drop in the slope in November. Perhaps the holiday season resulted in a slower rate of change.*

APPENDIX B

Blank Forms for the Monitoring System

This appendix provides blank forms for implementing the monitoring system.

This appendix includes:

- Event Log.
- Ongoing Services Provided Log.
- Media Coverage Log.
- Resources Generated Log.
- Tally Sheet for summarizing monitoring data.

Event Log

Site:

Recorder:

Using this form, describe 1) actions taken to bring about changes in the community that are related to reducing risks for cardiovascular diseases and 2) changes in *programs* (e.g., new after-school physical fitness activities), *policies* (e.g., worksite cafeteria offers at least one heart healthy alternative), and *practices* (e.g., labeling heart healthy foods at a local supermarket) that are related to reducing risks for cardiovascular diseases.

Code	Date (m/d/y)	Event	Description
		Describe the event in detail. Include: a. Why is it important? b. What happened as a result?	a. Who was involved? b. What organizations were collaborators? c. What community sector or objective is this related to? d. Was this the first time this event happened?

Send this form by the first Friday of every month to the evaluators: _____

Ongoing Services Provided Log

Site:

Recorder:

Using this form, describe classes, workshops, screenings, or other informational or service programs provided to community members on a regular basis. Note whether this is the first time that this service has been provided in the community.

Code	Date (m/d/y)	Service (e.g., workshop, class, screening)	Location of Service	No. of people attending	No. of hours	New Service? Yes/No

Send this form by the first Friday of every month to the evaluators: _____

Media Coverage Log

Site:

Recorder:

MEDIA COVERAGE Please attach copies of newspaper articles, etc.			
Date (m/d/y)	Topic of Media Coverage (e.g., announcing a new program)	Media Type (e.g., newspaper, TV, radio)	No. of Newspaper Column Inches or Broadcast Minutes (e.g., 4 inches, 2 minutes)

Send this form by the first Friday of every month to the evaluators: _____

Resources Generated Log

Site:

Recorder:

RESOURCES GENERATED Include cash and grants (e.g., United Way grants and Rotary cash donation) and in-kind donations (e.g., free professional service and food donation).			
Date (m/d/y)	Source	In-kind Dollar Amount	Cash/Grants Amount

Send this form by the first Friday of every month to the evaluators: _____

Tally Sheet

Project: _____ Year: _____

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
CA	No.											
	Cum.											
CC	No.											
	Cum.											
SP	No.											
	Cum.											
PP	No.											
	Cum.											
Media	No.											
	Cum.											
RG \$	No.											
	Cum.											
RG units	No.											
	Cum.											

Cum. = Cumulative

APPENDIX C

Portions of the 1995 Behavioral Risk Factor Questionnaire that relate to CVD

1995 Behavioral Risk Factor Questionnaire

FIPS STATE CODE	STRATUM CODE	PSU NUMBER	RECORD NUMBER	DATE OF INTERVIEW MM DD YY	ID
<div style="border: 1px solid black; width: 30px; height: 30px; margin: 0 auto;"></div>	<div style="border: 1px solid black; width: 30px; height: 30px; margin: 0 auto;"></div>	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>	<div style="border: 1px solid black; width: 30px; height: 30px; margin: 0 auto;"></div>	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto;"></div>	<div style="border: 1px solid black; width: 50px; height: 30px; margin: 0 auto;"></div>
(1-2)	(3)	(4-8)	(9)	(10-15)	(16-17)

HELLO, I'm _____ calling for the _____.

We're doing a study of the health practices of _____ residents.

Your phone number has been chosen randomly by the _____ to be included in the study, and we'd like to ask some questions about things people do which may affect their health.

Is this _____

Area code	Prefix	Suffix
<div style="border: 1px solid black; width: 40px; height: 30px; margin: 0 auto;"></div>	<div style="border: 1px solid black; width: 40px; height: 30px; margin: 0 auto;"></div>	<div style="border: 1px solid black; width: 40px; height: 30px; margin: 0 auto;"></div>
(18-20)	(21-23)	(24-25)

Thank you very much, but I seem to have dialed the wrong number. It's possible that your number may be called at a later time. STOP

Is this a private residence?

Thank you very much, but we are only interviewing private residences. STOP

	Date	Time	Time	Time	ID	Comments
<input type="radio"/> Line busy	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	
<input type="radio"/> No answer	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	

Appointments:

	Today's date/time	Spoke with	Ask for	Callback date/time	ID	Comments
1.	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	
2.	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	

Refusals:

	Date/time	Spoke with	ID	Comments
1st	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	
2nd	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px;"></div>	

Call Disposition Codes

- | | |
|--|---|
| 01 - Completed interview.
02 - Refused interview.
03 - Nonworking number.
04 - No answer (multiple times).
05 - Business phone.
06 - No eligible respondent at this number. | 07 - No eligible respondent could be reached during time period.
08 - Language barrier prevented completion of interview.
09 - Interview terminated within questionnaire.
10 - Line busy (multiple tries).
11 - Selected respondent unable to respond because of physical or mental impairment. |
|--|---|

Edited by: _____

Date: ____/____/____

Final disposition of telephone call:

(26-27)

Wind down:

(28)

Our study requires that we randomly select one adult who lives in your household to be interviewed. How many members of your household, including yourself, are 18 years of age or older?

--	--

(29-30)

If "1" Are you the adult?

If "yes" Then you are the person I need to speak with. Go to page 3

If "no" May I speak with him or her? Go to "correct respondent" at bottom of page

How many of these adults are men and how many are women?

Men

--

(31)

Women

--

(32)

Who is the oldest man who presently lives in this household?
Who is the next oldest man who presently lives in this household?
Etc.

Who is the oldest woman who presently lives in this household?
Who is the next oldest woman who presently lives in this household?
Etc.

Suffix: _____

Last digit of phone number

Name or Relationship		Last digit of phone number										
		0	1	2	3	4	5	6	7	8	9	
1.		1	1	1	1	1	1	1	1	1	1	1.
2.		2	1	2	1	2	1	2	1	2	1	2.
3.		3	1	2	3	1	2	3	1	2	X	3.
4.		1	2	3	4	1	2	3	4	X	X	4.
5.		2	3	4	5	1	2	3	4	5	1	5.
6.		5	6	1	2	3	4	X	X	X	X	6.
7.		2	3	4	5	6	7	1	X	X	X	7.
8.		8	1	2	3	4	5	6	7	X	X	8.

The person in your household that I need to speak with is _____.

If "you," go to page 3

To correct respondent



Hello, I'm _____ calling for the _____. I'm a member of a special research team. We're doing a study of _____ residents regarding their health practices and day-to-day living habits. You have been randomly chosen to be included in the study from among the adult members of your household.

Section 3: Hypertension Awareness

9. About how long has it been since you last had your blood pressure taken by a doctor, nurse, or other health professional? (44)

Read Only if Necessary

- a. Within the past 6 months (1 to 6 months ago) 1
- b. Within the past year (6 to 12 months ago) 2
- c. Within the past 2 years (1 to 2 years ago) 3
- d. Within the past 5 years (2 to 5 years ago) 4
- e. 5 or more years ago 5
- Don't know/Not sure 7
- Never *Go to Q. 12 (p. 8)* 8
- Refused 9

10. Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure? (45)

- a. Yes 1
- b. No *Go to Q. 12 (p. 8)* 2
- Don't know/Not sure *Go to Q. 12 (p. 8)* 7
- Refused *Go to Q. 12 (p. 8)* 9

11. Have you been told on more than one occasion that your blood pressure was high, or have you been told this only once? (46)

- a. More than once 1
- b. Only once 2
- Don't know/Not sure 7
- Refused 9

Section 4: Cholesterol Awareness

12. Blood cholesterol is a fatty substance found in the blood. Have you ever had your blood cholesterol checked? (47)

- a. Yes 1
- b. No *Go to Q. 15 (p. 9)* 2
- Don't know/Not sure *Go to Q. 15 (p. 9)* 7
- Refused *Go to Q. 15 (p. 9)* 9

13. About how long has it been since you last had your blood cholesterol checked? (48)

Read Only if Necessary

- a. Within the past year (1 to 12 months ago) 1
- b. Within the past 2 years (1 to 2 years ago) 2
- c. Within the past 5 years (2 to 5 years ago) 3
- d. 5 or more years ago 4
- Don't know/Not sure 7
- Refused 9

14. Have you ever been told by a doctor or other health professional that your blood cholesterol is high? (49)

- a. Yes 1
- b. No 2
- Don't know/Not sure 7
- Refused 9

Section 7: Tobacco Use

21. Have you smoked at least 100 cigarettes in your entire life? (57)

- 5 packs =
100 cigarettes
- a. Yes 1
- b. No Go to Q. 27 (p. 15) 2
- Don't know/Not sure Go to Q. 27 (p. 15) 7
- Refused Go to Q. 27 (p. 15) 9

22. Do you smoke cigarettes now? (58)

- a. Yes 1
- b. No Go to Q. 26 (p. 14) 2
- Refused Go to Q. 27 (p. 15) 9

23. On how many of the past 30 days did you smoke cigarettes? (59-60)

- a. Number of days If less than 30, go to Q. 24a (p. 14) — —
- b. None Go to Q. 26 (p. 14) 8 8
- Don't know/Not sure 7 7
- Refused 9 9

24. On the average, about how many cigarettes a day do you now smoke? (61-62)

- 1 pack =
20 cigarettes
- Number of cigarettes Go to Q. 25 (p. 14) — —
- Don't know/Not sure Go to Q. 25 (p. 14) 7 7
- Refused Go to Q. 25 (p. 14) 9 9

24a. On the average, when you smoked during the past 30 days, about how many cigarettes did you smoke a day? (63-64)

1 pack = 20 cigarettes	Number of cigarettes	Go to Q. 27 (p. 15)	— —
	Don't know/Not sure	Go to Q. 27 (p. 15)	7 7
	Refused	Go to Q. 27 (p. 15)	9 9

25. During the past 12 months, have you quit smoking for 1 day or longer? (65)

- a. Yes Go to Q. 27 (p. 15) 1
- b. No Go to Q. 27 (p. 15) 2
- Don't know/Not sure Go to Q. 27 (p. 15) 7
- Refused Go to Q. 27 (p. 15) 9

26. About how long has it been since you last smoked cigarettes regularly, that is, daily? (66-67)

Read Only if Necessary

- a. Within the past month (0 to 1 month ago) 0 1
- b. Within the past 3 months (1 to 3 months ago) 0 2
- c. Within the past 6 months (3 to 6 months ago) 0 3
- d. Within the past year (6 to 12 months ago) 0 4
- e. Within the past 5 years (1 to 5 years ago) 0 5
- f. Within the past 15 years (5 to 15 years ago) 0 6
- g. 15 or more years ago 0 7
- Don't know/Not sure 7 7
- Never smoked regularly 8 8
- Refused 9 9



Module 2: Fruits and Vegetables

These next questions are about the foods you usually eat or drink. Please tell me how often you eat or drink each one, for example, twice a week, three times a month, and so forth. Remember, I am only interested in the foods you eat. Include all foods you eat, both at home and away from home.

1. How often do you drink fruit juices such as orange, grapefruit, or tomato? (148–150)

- a. Per day 1 _ _
- b. Per week 2 _ _
- c. Per month 3 _ _
- d. Per year 4 _ _
- e. Never 5 5 5
- Don't know/Not sure 7 7 7
- Refused 9 9 9

2. Not counting juice, how often do you eat fruit? (151–153)

- a. Per day 1 _ _
- b. Per week 2 _ _
- c. Per month 3 _ _
- d. Per year 4 _ _
- e. Never 5 5 5
- Don't know/Not sure 7 7 7
- Refused 9 9 9

3. How often do you eat green salad? (154–156)
- | | | | |
|---------------------------|---|----|----|
| a. Per day | 1 | __ | __ |
| b. Per week | 2 | __ | __ |
| c. Per month | 3 | __ | __ |
| d. Per year | 4 | __ | __ |
| e. Never | 5 | 5 | 5 |
| Don't know/Not sure | 7 | 7 | 7 |
| Refused | 9 | 9 | 9 |

4. How often do you eat potatoes, not including french fries, fried potatoes, or potato chips? (157–159)
- | | | | |
|---------------------------|---|----|----|
| a. Per day | 1 | __ | __ |
| b. Per week | 2 | __ | __ |
| c. Per month | 3 | __ | __ |
| d. Per year | 4 | __ | __ |
| e. Never | 5 | 5 | 5 |
| Don't know/Not sure | 7 | 7 | 7 |
| Refused | 9 | 9 | 9 |



5. How often do you eat carrots? (160–162)
- | | | | |
|---------------------------|---|---|---|
| a. Per day | 1 | — | — |
| b. Per week | 2 | — | — |
| c. Per month | 3 | — | — |
| d. Per year | 4 | — | — |
| e. Never | 5 | 5 | 5 |
| Don't know/Not sure | 7 | 7 | 7 |
| Refused | 9 | 9 | 9 |

6. Not counting carrots, potatoes, or salad, how many servings of vegetables do you usually eat? (163–165)
- | | | | | |
|---|---------------------------|---|---|---|
| Example: a serving of vegetables at both lunch and dinner would be two servings. | a. Per day | 1 | — | — |
| | b. Per week | 2 | — | — |
| | c. Per month | 3 | — | — |
| | d. Per year | 4 | — | — |
| | e. Never | 5 | 5 | 5 |
| | Don't know/Not sure | 7 | 7 | 7 |
| | Refused | 9 | 9 | 9 |

Module 4: Exercise

The next few questions are about exercise, recreation, or physical activities other than your regular job duties.

1. During the past month, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise? (184)

- a. Yes 1
- b. No *Go to Next Module* 2
- Don't know/Not sure *Go to Next Module* 7
- Refused *Go to Next Module* 9

2. What type of physical activity or exercise did you spend the most time doing during the past month? (185–186)

Activity (specify): _____
See coding list A

Refused *Go to Q. 6* 9 9



Ask Q. 3 only if answer to Q. 2 is running, jogging, walking, or swimming. All others go to Q. 4.

3. How far did you usually walk/run/jog/swim? (187–189)

See coding
list B if
response is
not in miles
and tenths.

Miles and tenths — —.

Don't know/Not sure 7 7 7

Refused 9 9 9

4. How many times per week or per month did you take part in this activity during the past month? (190–192)

a. Times per week 1 — —

b. Times per month 2 — —

Don't know/Not sure 7 7 7

Refused 9 9 9



5. And when you took part in this activity, for how many minutes or hours did you usually keep at it? (193–195)

Hours and minutes —:—

Don't know/Not sure 7 7 7

Refused 9 9 9

6. Was there another physical activity or exercise that you participated in during the last month? (196)

a. Yes 1

b. No *Go to Next Module* 2

Don't know/Not sure *Go to Next Module* 7

Refused *Go to Next Module* 9

7. What other types of physical activity gave you the most exercise during the past month? (197–198)

Activity (specify):
See coding list A

Refused *Go to Next Module* 9 9



Ask Q. 8 only if answer to Q. 7 is running, jogging, walking, or swimming. All others go to Q. 9.

8. How far did you usually walk/run/jog/swim? (199–201)

See coding
list B if
response is
not in miles
and tenths.

Miles and tenths —.—

Don't know/Not sure 7 7 7

Refused 9 9 9



9. How many times per week or per month did you take part in this activity? (202–204)

a. Times per week 1 _ _

b. Times per month 2 _ _

Don't know/Not sure 7 7 7

Refused 9 9 9

10. And when you took part in this activity, for how many minutes or hours did you usually keep at it? (205–207)

Hours and minutes _ : _ _

Don't know/Not sure 7 7 7

Refused 9 9 9



Activity Codes and Intensity Factors for Common Leisure Activities

Coding List A

Code description

01. Aerobics class
02. Backpacking
03. Badminton
04. Basketball
05. Bicycling for pleasure
06. Boating (canoeing, rowing,
sailing for pleasure or camping)
07. Bowling
08. Boxing
09. Calisthenics
10. Canoeing/rowing—in competition
11. Carpentry
12. Dancing-aerobics/ballet
13. Fishing from river bank or boat
14. Gardening (spading, weeding,
digging, filling)
15. Golf
16. Handball
17. Health club exercise
18. Hiking—cross-country
19. Home exercise
20. Horseback riding
21. Hunting large game—deer, elk
22. Jogging
23. Judo/karate
24. Mountain climbing
25. Mowing lawn
26. Paddleball
27. Painting/papering house

Code description

28. Racketball
29. Raking lawn
30. Running
31. Rope skipping
32. Scuba diving
33. Skating—ice or roller
34. Sledding, tobogganing
35. Snorkeling
36. Snowshoeing
37. Snow shoveling by hand
38. Snow blowing
39. Snow skiing
40. Soccer
41. Softball
42. Squash
43. Stair climbing
44. Stream fishing in waders
45. Surfing
46. Swimming laps
47. Table tennis
48. Tennis
49. Touch football
50. Volleyball
51. Walking
52. Waterskiing
53. Weight lifting
54. Other_____
55. Bicycling machine exercise
56. Rowing machine exercise

Coding List B

Lap Swimming

<i>Size pool</i>	<i>Laps</i>
50 ft. pool	10 laps = .1 mile
100 ft. pool	5 laps = .1 mile
50 meter pool	3 laps = .1 mile

Running/Jogging/Walking

1/2 mile = .5 mile
1/4 mile = .3 mile
1/8 mile = .1 mile
1 block = .1 mile



Module 5: Weight Control

1.

Are you now trying to lose weight?

(208)
- a.

Yes *Go to Q. 3*

1
- b.

No

2
- Don't know/Not sure

7
- Refused

9
2.

Are you now trying to maintain your current weight, that is to keep from gaining weight

(209)
- a.

Yes

1
- b.

No *Go to Q. 6*

2
- Don't know/Not sure *Go to Q. 6*

7
- Refused *Go to Q. 6*

9
3.

Are you eating either fewer calories or less fat to...
- lose weight? [*if "Yes" on Q. 1*]
- keep from gaining weight? [*if "Yes" on Q. 2*]

(210)
- Probe
for
which

a.

Yes, fewer calories

1
- b.

Yes, less fat

2
- c.

Yes, fewer calories and less fat

3
- d.

No

4
- Don't know/Not sure

7
- Refused

9



4. Are you using physical activity or exercise to...
lose weight? *[if “Yes” on Q. 1]*
keep from gaining weight? *[if “Yes” on Q. 2]* (211)
- | | |
|---------------------------|---|
| a. Yes | 1 |
| b. No | 2 |
| Don’t know/Not sure | 7 |
| Refused | 9 |
5. How much would you like to weigh? (212-214)
- | | | |
|---------------------------|-------|--------|
| Weight | — — — | pounds |
| Don’t know/Not sure | 7 7 7 | |
| Refused | 9 9 9 | |
6. In the past 12 months, has a doctor, nurse, or other health professional given you advice about your weight? (215)
- | | | |
|-----------------------|---------------------------------------|---|
| Probe
for
which | a. Yes, lose weight | 1 |
| | b. Yes, gain weight | 2 |
| | c. Yes, maintain current weight | 3 |
| | d. No | 4 |
| | Don’t know/Not sure | 7 |
| | Refused | 9 |

About the Authors

Dr. Stephen B. Fawcett is a Professor in the Department of Human Development and Director of the Work Group on Health Promotion and Community Development at the University of Kansas. He conducts a program of research and public service in community health and development and serves as a mentor for doctoral and undergraduate students in behavioral sciences and public health.

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Dr. Adrienne Paine-Andrews is Associate Director of the Work Group on Health Promotion and Community Development and Courtesy Assistant Professor of Human Development at the University of Kansas. She served as Principal Investigator for research grants evaluating Kansas LEAN (Low-Fat Eating for America Now) and School/Community initiatives to reduce risks for cardiovascular diseases.

Ms. Kari J. Harris, a Research Associate with the Work Group and a doctoral student in the Department of Human Development, University of Kansas, headed many of the Work Group's projects related to the prevention of cardiovascular diseases.

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Dr. Thomas L. Schmid is a Senior Evaluation Specialist with the National Center for Chronic Disease Prevention and Health Promotion at CDC. As a research scientist, he provides consultation on the design, implementation, and evaluation of cardiovascular diseases prevention projects sponsored by CDC and other federal, State, private, and international organizations.

